SCHEDULE AWARD CHANGES

Prior to 1940	No schedule award; wage earning capacity only.
From 1940 to 1957	Schedule award for 100 percent major members with entitlement to wage-earning capacity after schedule award expires. Injury must be to scheduled member only.
	Schedule award for minor members and less than 100 percent to major members with no entitlement to wage-earning capacity after schedule award expires. Is entitled to TTD while so disabled and under active medical treatment. STUCZYNSKI 12 ECAB 159, NICHOLS 24 ECAB 139-144.
Prior to Sep 13, 1957	Civil Service Commission and FECA (schedule award) not authorized. Must elect. PM #12.
From 1957 to 1966	Same as 1940 to 1957. However, schedule award may be paid if permanent partial disability is confined to scheduled member, regardless of location of injury. If other "significant disability" outside scheduled member, no schedule award payable. Significant disability is that which will require treatment and/or cause loss of wage-earning capacity.
From 1966 to Present	Wage-earing capacity entitlement after any schedule award. Schedule award payable regardless of location of other "significant disability."
From 1974 to Present	Schedule award for internal organs

CA-7: CLAIM FOR COMPENSATION ON ACCOUNT OF TRAMATIC INJURY

General Principles

- The CA-7 is used to initiate action for compensation when the injured party is disabled beyond 45 calendar days. It covers the following:

  - dependency status
  - health benefits
  - optional insurance
  - benefits
  - pay losses, and/or
  - time off covered by leave

- In addition the CA-7 may be submitted with a CA-2 when the claimant is filing a claim for compensation on account of a recurrence of an injury.

The CA-7 has 40 items, all of which may not apply to any one claimant. The important items and their significance is explained in the chart on page(s) 100 - 102. Following the chart is a typical CA-7, doctors report, agency and claimant's letter. Data from these documents and the CA-7, are used to make a determination as to whether the claimant is eligible for some type of compensation, such as:

- Temporary Total Disability
- Loss of Wage Earning Capability
- Schedule Award
- Disfigurement

NOTE: Only the CA-7 is explained on pages(s) 100-102, items on the CA-4 have similar significance.

Items	Significance or Use
4. Is claim being made for wage loss	• If Yes is checked, denotes claim for payment or loss of wages (LWOP or LWEC). • If No, find out why claim submitted.
5. Scheduled award	• If Yes, have claimant obtain a medical evaluation. • If No, claimant may be applying for LWOP or LWEC. See #4 above.
6. Period of Comp. for LWOP	LWOP claimed, see next item, #7.
7. Pay received for #6	• Yes, cannot pay compensation; advise claimant to buy back leave. • No, entitled to compensation if supported by medical evidence. • If LWOP is not claimed, claimant is requesting something else or using the wrong form.
8. Third-Party	If "Yes", see next item. No - Not a 3rd Party case.
9. Status of Third-Party	
10. Armed Services	• If "Yes", possible VA dual benefits. - VA or military retirement. • If "no", at least no VA or retirement military benefits involved.
11. VA Benefits	• If "Yes", claimant must furnish claim information. See section on Dual Benefits. • If "No", insignificant.
12. Other Federal Benefits	• If "Yes", claimant may have to elect between FECA and other benefit. See section on Dual Benefits. • If "No", insignificant.

Items	Significance or Use
13. Dependents	• If "Yes", comp rate is 3/4. • If "No", comp rate is 2/3. o Check to see if dependents are at same address. At least one must reside at address. • Yes, alright. • No, claimant qualifies as having "no" dependents.
14. Dependents	Used to verify dependent status
19. Pay Rate	Pay information given for: Date of Injury and Date Employee stopped work (date disability began) - Pay higher of <u>two</u> rates.
20. Premium Pay	If "Yes", request total amount for one year. If "No", insignif-cant.
21. Work Week	Employees usually paid by work week. If Sun. is marked, claim-ant may be entitled to Sun. premium pay.
22. Worked last 11 mos. prior to injury	• If "Yes", all right • If "No", check item 23. Em-ployee may be temporary or part-time.
23. Continuation of #22	• If "Yes", use base pay as indi-cated. • If "No", pro-rate base pay
25. Leave used	• If employee used leave, not eligible for compensation; however, employee can buy back leave. • If employee did <u>not</u> use leave, eligible for LWOP.
27. Inclusive dates regular pay continued during disability	Advises inclusive period of COP.

Items	Significance or Use
28. Gross dollar amt. of regular pay	Significant for third-party only
29. Change of pay during COP	If yes, CE cannot use increase for comp. purposes.
30. Date and hour all pay stopped.	Provides first day CE can pay claimant comp.
31. Period for which comp. is claimed	FECA pays only for period claimed
32. Health benefits	Used in "setting" up payments.
33. Date & Hour returned to work	• If "yes", date of final payment. • If "no", send CA-8 with check.
34. Pay rate at time returned to work	• If higher, insignificant. • If lower, CE must find out "why".
36. Did work change	• If "yes", claimant may still be having problem. Could possibly be recurrences. • If "no", claimant probably has recovered.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*: SMITH, JAMES J.

2. Social Security Number: 008-14-7645

3. OWCP File Number *(If known)*: A1-127954

4. Is Claim Being Made For Wage Loss? ☒ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? ☐ Yes ☐ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*: From: 4-10-75 Through: indefinite

7. Has Any Pay Been Received For The Period Shown In Item 6? ☐ Yes ☒ No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)*: $ _____ From _____ Through _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☒ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☒ No If Yes, Furnish → a. Service Number; b. Branch Of Service; c. Period Of Service *(Mo. day, year)* From: _____ Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☐ No If Yes, Furnish → a. Claim Number; b. Address of VA Office Where Claim is Filed; c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☒ No If Yes, Furnish → a. Claim Number; b. Date Annuity Began *(Mo., day, year)*; c. Amount of Monthly Payment $ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Sarah M. Smith	wife	2-7-40	yes	Box 89, Danvers, Mass.
Michael Smith	son	4-6-70	yes	same
Dorothy A. Smith	daughter	9-7-68	yes	same

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature: James J. Smith

16. Employee's Home Mailing Address *(Include Zip Code)*

17. Date *(Mo., day, year)*: 5-7-75

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$ 5.50 per hr.	$ per	$ per	$ per
Date Employee Stopped Work →	$ per	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount

Type N/A $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday

S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?

☒ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?

☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service

12 years

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*
N/A		

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes

$ 5.50 per hr.

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave

From: 12-2-74 Through: 1-17-75

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave

$ _____

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*

4-10-75 ☒ AM ☐ PM

31. Period For Which Compensation Is Claimed

From: 4-10-75 Through: continuing

32. Deductions:

a. Was Employee Enrolled On Date Pay Stopped? Health Benefits ☒ Yes ☐ No Optional Insurance ☐ Yes ☒ No

b. If Yes, Furnish Code Number. 1 0 2 - . . .

c. If Yes, Give Date Through Which Deductions Were Last Made.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*

has not ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work

$ _____ per ____

35. Show Work Week On Return To Work If Other Than Monday Through Friday

S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

N/A

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Daniel Small Daniel Small	Personnel Assistant Admin.	5-17-75

CA-7
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103a

May 10, 1975

Mr. Sam Goodheart
U.S. Department of Labor
Office of Workers'
Compensation Programs
J.F.K. Building
Boston, Massachusetts

Dear Mr. Goodheart:

Mr. Smith was originally seen by me on December 3, 1974, with a history that he had fallen at work and injured his left shoulder at Portsmouth Navy Yard.

At that time he complained of pain extending from the lower left side of the neck, shoulder and scapula areas down into the elbow area. He had great difficulty in raising his arm laterally although forward lifting could be done fairly well. This condition settled in the area of the shoulder and it seems that the condition was chiefly a traumatic bursitis.

I saw Mr. Smith last January 31, 1975 when his complaint had subsided to the degree that he decided he wanted to return to duty.

On April 4, 1975, Mr. Smith returned to my office and the symptoms had become more pronounced.

I referred Mr. Smith to Dr. Frost in Danvers, Mass., an associate, and he diagnosed the condition as bicipital tendonitis of the left shoulder. I have continued with the conservative care and believe that with the treatment of an occasional intra-articular shot with cortisone directly into the shoulder joint may prove to provide some relief to this patient.

Mr. Smith will continue under my care. When last seen on May 6, he was still not able to raise his left arm to higher than the horizontal in a lateral direction. He had constant pain extending down the shoulder to the hand.

It is my opinion the fall was the direct cause of this man's present disability as he had no history of any symptoms of a similar nature prior to that fall.

Sincerely,

A. J. Good, M.D.

From: THE PORTSMOUTH NAVAL SHIPYARD, PORTSMOUTH, NEW HAMPSHIRE

Date: April 25, 1975

Re: Injury - James J. Smith - December 2, 1974

Gentlemen:

Mr. Smith returned to duty status on January 17, 1974, following his injury of December 2, 1974.

He was placed on full duty status and performed his assigned duties although he did complain of pain and lameness of the left arm and shoulder area, especially when he was assigned to work aboard ships which required him to climb ladders and paint overhead areas.

Mr. Smith stopped work complaining that he could not continue work on April 10, 1975.

Sincerely,

Daniel Small
Personnel Assistant
Administrative

April 25, 1975

Dear Sir:

In answer to your letter of April 21, 1975.

From the time of my fall I had constant pain in left arm and shoulder and I was treated by Dr. Good in January and came back to work at the yard.

I could do shop work ok because it was light duty and my boss gave me all the breaks he could doing booth painting in the shop and we had a lot of that work at that time.

In April around the first week of the month I had to go on the ships. I could barely climb the ladders and could only use my right arm because my sore arm got really bad and I went back to Dr. Good. He sent me to see Dr. Frost and they said that they would send letters to you.

Please help me as soon as you can because I need the money to support my family.

Yours truly,

James J. Smith.

DETERMINING COMPENSATION

References: . FECA 8112, 8114
. Procedure Manual, 1-1100

After a claim has been accepted and entitlement to compensation has been determined, the next step is to determine the amount of compensation to be awarded. To arrive at a total weekly compensation figure, three variables are involved: pay rate, comp. rate and CPI.

- DEFINITIONS

  - o PAY RATE: Claimant's pay rate (wages or salary) used for compensation purposes.

    - Base Pay Rate: Claimant's basic weekly wage or salary.

    - Premium Pay Rate: Wages or salary earned by claimant for weekend, holiday or night duty. (Also called "Shift Differential" or "Sunday Premium, Night Differential or Holiday Pay".)

    - Miscellaneous Increments: Refer to Procedure Manual, pages 1-11-6 - 1-11-7.

    - Total Weekly Pay Rate: Weekly base pay and premium pay. (See Catalano, 24 ECAB 170.) Does NOT include "overtime" pay.

  - o COMP. RATE: Percentage or amount of pay rate to which claimant is entitled as compensation for injury or disease, as long as claimant's total weekly pay rate is MORE THAN the "minimum" rate of pay.

    - Comp. Rate is 3/4 (75%) of pay rate, if claimant has dependents.

    - Comp. Rate is 2/3 (66 2/3%) of pay rate, if claimant has no dependents.

    - "Minimum" Comp. Rate: 75% of GS-2, Step 1(GS-2/1); only applies to TTD.

    - "Maximum" Comp. Rate: 75% of GS-15, Step 10 (GS-15/10).
      NOTE: The "minimum" in disability refers to "comp. rate"; the "minimum" in death refers to "pay rate".

- If claimant's weekly pay rate is LESS THAN the "minimum" comp. rate (GS-2/1), then you pay the weekly comp. at 100% (equivalent to the weekly pay rate).

  . However, if claimant's weekly pay rate is MORE THAN the "minimum" comp. rate, then multiply the weekly pay by the appropriate "comp. rate" (2/3 or 3/4), and compare with "minimum" comp. rate---pay whichever is greater.

- Weekly Comp. Rate

  a) When weekly pay rate is LESS THAN the "minimum": Weekly Comp. Rate = Total Weekly Pay Rate

  b) When weekly pay rate is MORE THAN the "minimum": Weekly Comp. Rate = Total Weekly Pay Rate x "Comp. Rate"

o CPI (Consumer Price Index; also called "cost-of-living" increase): The CPI is established by the Bureau of Labor Statistics (BLS) when they determine that the cost of living increases more than 3% for 3 consecutive months.

  - Usually, the CPI changes twice a year, but it may change more, or less, frequently. All CPI's are listed as a percentage with their effective dates, in a CPI Book (in your office). A list is also provided in the Resource Book, page 113 .

  - It is unusual to have a CPI involved when the claimant will be on the Daily Roll.

  - If a claimant is entitled to a CPI, then the WEEKLY comp. rate is adjusted to include this increment in the TOTAL WEEKLY COMP. award.

o TOTAL WEEKLY COMP.: The final compensation amount to which claimant is entitled on a weekly basis.

To Determine TOTAL WEEKLY PAY RATE:

(See also Blaise, 22 ECAB 115, and Gay 23 ECAB 272.)

o Types of Pay Rates - Use the highest of these:

→

1) Date of Injury (DOI): use base pay rate as of date of injury.

2) Date of Recurrence (DOR): use base pay rate as of recurrence that occurs at least 6 months after first return to full-time duty.

3) Date of Disability (DOD or DDB): use base pay rate as of date disability began (e.g., date employee stopped work)

4) Date of Last Exposure: use this base pay rate in disease cases

- In hearing loss cases: use pay rate in effect as of date employee stopped working (DDB). If claimant is still working, use pay rate in effect on Date of Last Exposure. Usually the DDB is the same as the "DMMI" (which is usually the same date the SA begins and date of audiogram).

o STEPS to determine TOTAL WEEKLY PAY RATE:

1) Determine whether claimant lost time from work.

- Look at: CA-1 (item #29); CA-2 (item #33); CA-2a (item #10); CA-4 (item #14); CA-7 (item #19, 30)

- Sometimes CA-800 is helpful to indicate pay rate used for comp. purposes as of last date claimant was paid

  o No time lost - Use DOI

  o Time lost - Use DOR; if claimant has a recurrence more than 6 months after his/her first return to full-time duty, and if recurrent pay rate is higher, then use DOR pay rate.

  o Date Disability Began - if pay rate on Date of Disability is higher than that on DOI, then use pay rate on Date of Disability.

2) Determine whether claimant is entitled to PREMIUM pay. Look at claimant's normal work week/hours.

  o Normally works Sunday - entitled to Sunday premium pay.

CIVIL EMPLOYEE

References:
- FECA 8101 (1) - "Definitions"
- Procedure Manual, Part 1, Chapter 1-800, pp. 1-8-16 to 24
- FECA Program Memorandum 127
- FPM, Chapter 810, Sec. 3.2.

The category of civil employee is determined by FECA 8101 (1) (A): "A civil officer or employee of any branch of the government of the U.S., including an officer or an employee of an instrumentality wholly owned by the U.S." The FECA now covers members of the following groups, in addition to civilian employees of Federal Agencies and the U.S. Postal Service:

1. District of Columbia Employees (D.C. #25 only)
*2. Reserve Officer Training Corps (ROTC)
*3. Civil Air Patrol (CAP)
4. Peace Corps - D.C. #50, then transferred
5. Job Corps
*6. Volunteers in Service to America (VISTA)
7. Veterans Administration - Volunteer Hospital Workers
8. Neighborhood Youth Corps
9. National Teacher Corps
10. Youth Conservation Corps
*11. Non-Federal Law Enforcement Officers
*12. White House Employees
13. Office of Economic Opportunity (administrative employees only)
*14. Members of Congress and their staffs
*15. Civilian Conservation Corps (CCC)
*16. Federal Emergency Administration
*17. Contractors, Pacific Naval Air Bases
*18. Civil Works Administration
*19. Florida Hurricane
*20. National Youth Administration
*21. War Claims
*22. Work Project Administration
*23. Foreign National Employees
24. Students of Service Academies
25. State National Guard members when in civilian status
26. Department of Agriculture County Agents
27. Student Aides

Note that volunteers are covered under the Act (see Program Memo 127); temporary and part-time employees are covered.

* Handled primarily by "Special Claims" (D.C. #50)

light of all the facts, in the light of our experience, particularly in the light of common sense, but certainly the fact that it bears the label "circumstantial" is no basis whatsoever for rejecting it. So that when circumstantial facts have been established to the satisfaction of the examiner and these are the only evidence available and they provide a logical inference to the fact which must be determined, it most certainly is proper and required that the examiner make his or her determination on such evidence in accordance with it".

Some of the types of circumstantial evidence commonly encountered are:

(a) Negative Evidence - This type of evidence is based upon such things as failure to recollect, absence of records, etc. Ordinarily such evidence will not successfully rebut positive evidence. The Board recognized this fact in the case of Edward Gardner (Docket No. 48-94) where it stated: "Such evidence is, of course, negative evidence as to what did not occur. Compared with positive evidence it normally should be regarded as the weaker".

(b) Conclusions or Opinions - A statement affirming or denying the existence or occurrence of something may be labelled as a conclusion if it is unexplained or does not contain sufficient facts to show the basis of the statement. The Claims Examiner must use great care in accepting the conclusions or opinions of witnesses. Wherever practicable the examiners should ascertain the facts and arrive at their own conclusions. An example of a conclusion was cited by the Board in the case of John H. Quimnelly (1 ECAB 195) where it stated: "A statement submitted 5 years after the event to the effect that to his personal knowledge the claimant received an injury on given date in given manner, is largely a conclusion and where it does not contain sufficient recitals to show what factual basis existed to support the conclusion is not evidence of sufficient probative value to support a claim".

OWCP rejected a claim for compensation for death in a case where an employee was bludgeoned to death in a foreign country shortly after midnight. The reason for disallowance was that the death was

not the result of a personal injury sustained in the performance of duty. The only evidence on this point or the circumstances of death was the unexplained statement by the officials of the employing establishment that the death did not occur in the performance of duty. On appeal, the Board stated: "The determination to be made under the Federal Employees' Compensation Act is whether the employee was killed in the performance of his duties. In order to make this determination the facts with respect to the duties actually performed must be first ascertained. There is no evidence in the record to establish what the duties of the employee were. The statement of the officials of the employing establishment constitutes legal conclusions and cannot be the basis for the determination. It is essential that the record contain a complete description of the employee's duties involved in his assignment, a specification of the time and manner of the performance of such duties, and other relevant information." (Clara A. Ross, Docket No. 54-351)

(c) Hearsay Evidence - Much has been written about the admission of hearsay evidence and its use to support an award of compensation.

Under the "rules of evidence" hearsay evidence is chiefly objectionable because it affords no opportunity for cross-examination. Hearsay evidence is not necessarily untrue but it always involves the great danger of inaccuracy. The examiner must be particularly careful in the use of hearsay evidence. It may be considered for what it is worth in conjunction with all of the other evidence. Ordinarily, hearsay evidence should not be sufficient to overcome credible direct evidence or compelling circumstantial evidence. The examiner must remember much hearsay is worthless rumor or gossip but there is also such a thing as "persuasive hearsay".

There is also the question whether hearsay evidence alone is sufficient to support an award of compensation. If this is done, the examiner must indeed use great caution to be sure the award is not in fact based upon conjecture and surmize. Where this is done, the hearsay evidence must be of a character and sufficiency, considering all the circumstances, to satisfy a reasonable mind.

A different type of hearsay evidence was emphasized by the Board in the case of Abraham Finkelstein (2 ECAB 129). They stated that the claimant testified that he accidently stepped into dirt swept up by Custodian Fiore while walking with a foreman and was hit in head by Fiore with a broom handle. The record did not contain statements by either Fiore or the foreman, but did contain statements by persons not witnesses to the incident. The ECAB found that claimant precipitated fight with Fiore was based upon hearsay evidence which was not competent to overrule claimant's testimony, and the order was set aside.

INFERENCES and PRESUMPTIONS

An inference or presumption is the vehicle which a Claims Examiner must frequently use to "bridge the gap" between circumstantial evidence and the determination.

Inferences are deductive processes of reasoning based on experience and logic. A proper inference is entirely distinct from conjecture and surmize. It is proper for the Claims Examiner, when necessary, to use an inference to arrive at a determination of fact. The Claims Examiner must use care to ascertain the most reasonable and logical conclusion to be drawn from the known circumstances when there may be two or more possible deductions. Conclusions based on conjecture and surmize must be excluded by the Claims Examiner.

An example of a permissible inference was cited by the Board in the case of Carmen Sharp (Docket No. 52-12), where it stated that where claimant as incident of employment ate meals in employer's mess hall and contracted undulant fever which, according to medical evidence, probably resulted from drinking infected milk, it was permissible inference that claimant contracted disease from her employment.

The Board permitted no inference in the case of Bernice W. Curtis (1 ECAB 95), where it stated that where injury was broken arm and death was due to coronary occlusion, causal relationship may not readily be inferred, and proof would necessarily include opinions of medical experts, for question is peculiarly one exclusively within the field of knowledge of medical scientists.

A presumption is defined as "an inference as to the existence of one fact not certainly known, from the known existence of some other fact". A proper assumption is based on common

sense and may sustain a determination provided there is no credible direct evidence to the contrary. However, just as with an inference, the examiner must be sure that the presumption is the most logical conclusion to be drawn from the known facts and is not based upon conjecture and surmize. The application of a presumption requires great care, exceedingly good judgment and a high degree of common sense.

Take the case of an employee who enters the premises of his employer on a specific day at the place and time he usually arrived to report for work each day. He was checked through the entrance gate in the usual manner and at the usual time. A few minutes later he was instantly killed at a point directly enroute from the gate to his work-site. In the absence of direct testimony it would be a proper presumption to find that he was enroute to work and was killed while in the performance of duty. However, such presumption would be improper if direct testimony showed he was not scheduled to work that day but was in fact engaged in a personal errand not having any connection with his work.

UNWITNESSED INJURY

While it is desirable from the viewpoint of adjudication that there be eye witnesses to every injury, it does not follow that actual witnesses are a requisite of a valid claim for compensation. The purposes of the Act would be defeated on many occasions if eye witnesses were mandatory. This, of course, raises the very real and serious question for the examiner as to how to evaluate the facts in respect to the unwitnessed injury.

In the first place, in this kind of case, the claimant's testimony is the only positive or direct evidence which is available. By its very nature, such evidence must be accorded substantial probative value. The claimant's testimony may not be disregarded merely because he or she has an interest in the claim. This fact by itself does not mean claimant has falsified the claim. The claimant's testimony has probative value and is sufficient to establish a fact if it is uncontradicted, unequivocable, not discredited and no other compelling reason exists for disbelieving it. In other words, the claimant's allegations may not be disregarded merely because he or she has an interest in the claim. If a claimant's statement is disbelieved there must be evidence or a valid explanation to substantiate the disbelief.

The rule of "surrounding facts and circumstances" has been developed as a tool for the examiner in evaluating the evi-

dence in an unwitnessed injury. By this rule the "fact of injury" is established if the examiner finds the claimant's statements and subsequent course of action are consistent with the surrounding facts and circumstances and otherwise probably true. The term "surrounding facts and circumstances" varies in each specific case. As is so often true in compensation claims "each case is considered on its own merits".

The case of Jack Layton (Docket No. 54-340) typifies a situation where the Board found the surrounding facts and circumstances were not consistent with the claimant's allegation of injury. There the Board stated:

> "The evidence in the instant case does not meet that test for a number of reasons: Suffice to state there are basic inconsistencies in appellant's various versions of how the injury occurred. The lay evidence of co-workers fails to reveal contemporary knowledge of an injury having occurred. There is no substantial evidence that he had any disability for work following the injury or that he complained of any injury until August 12. It is well established that an arthritic knee condition of progressive nature existed long before July 15 and the medical evidence shows the absence of any physical indication of trauma. On the other hand, the evidence indicates there was a gradual increase in symptoms rather than the immediate disability normally anticipated where trauma is producing cause, and the medical evidence reveals a condition consistent with progressive degenerative arthritic changes".

Another example appears in the case of Estel L. Jones (Docket No. 55-385). There the Board said "such circumstances, as inaccurate date of alleged occurrence of injury, late notification of injury, lack of confirmation of injury, lack of need for medical treatment in connection therewith until 30 days later, and his work activity following the alleged injury" which were otherwise unexplained, cast sufficient doubt on the claimant's statement to outweigh the evidentiary value of his statements.

LIBERAL INTERPRETATION

Claims Examiners are frequently confronted with such terms as "liberal interpretation", "benefit of doubt", "beneficial purpose", "remedial legislation", etc. The meaning of such terms is simply that OWCP in its determinations is required to construe the Act in a liberal manner so that the beneficial purpose of the Act and the intent of Congress is accomp-

listed. OWCP must avoid strict adherence to the verbiage of the Act if it defeats the plain purpose of the Act.

The Claims Examiner should remember the liability of the United States in respect to the injury or death of an employee is limited to the benefits provided by the Act. Employees, their representatives and dependents are barred from seeking recovery in judicial proceedings. However, this does not mean the claims examiner may authorize the approval of claims which lack the essential requirements of the Act.

DETERMINING the "PROBATIVE" VALUE

- In the absence of rules limiting the admission of evidence, it follows that evidence of all types reaches OWCP's files. This fact makes the evaluation of evidence more difficult for the Claims Examiner. This is particularly true where the evidence is in conflict. It is therefore appropriate that some consideration be given to an enumeration of the types of evidence and the value to be assigned to such evidence. For our purpose here, the following charts might be helpful.

. Guidelines for Determining PROBATIVE VALUE:

Greater Value	Lesser Value
- Witness statements substantiate claim. (There is need for additional substantiation when dealing with psychiatric questions - e.g., abuse, harassment, persecutive, etc.)	- Absence of witness - Witness statements contradict claimant statement
- Definitive statement (either positive or negative)	- Indefinite statement, e.g., "I don't know", or "I can't confirm or deny"
- Consistency between claimant actions after injury and allegations of such actions	- Inconsistency between facts and allegations concerning claimant behavior
- Claimant's initial statement	- Later statement from claimant which differs from or contradicts earlier statement
- Consistency between claimant's duties and the alleged cause of injury	- Inconsistency or doubt concerning whether injury could have occurred in time, place, manner alleged

NOTE: Some conflicts in factual evidence may be irrelevant to the issue.

CATEGORY	NATURE OF	ACTION TO TAKE
Positive or Direct	Witness present when accident occurred. Saw it happen; describes it. Strongest type of evidence.	Always used
Circumstantial or Indirect	Frequently more than one conclusion can be drawn. Not witnessed.	Usually DO NOT USE
(1) Negative	Based upon such things as failure to recollect, absence of records, etc. Weak evidence.	Usually, DO NOT USE
(2) Conclusions/ opinions	Statements that affirm or deny the existence of something and are unexplained or lack sufficient facts to support them. Little value.	Usually DO NOT USE
(3) Hearsay	Information received at least second-hand by word of mouth; not necessarily untrue, but always involves the danger of inaccuracy. Weak evidence, cannot be rebutted.	Usually DO NOT USE

- In addition to the above categories, the claimant's statement of injury is considered a "statement of fact" if not challenged by the Employing Agency. The fact that he or she is an interested party does not compromise his/her statement provided the facts and circumstances of the injury are compatible with factors of employment. Also, under no circumstances does the quantity of evidence outweigh the quality of the evidence. The most important thing you are concerned with is whether or not it supports the claim.

"BENEFIT of DOUBT"

- "Benefit of doubt" is a factor which enters in making a decision to accept or deny a claim. It usually occurs when the evidence presented by the claimant is questionable or not clearly substantiated. You will encounter this situation when evaluating a claim for:

    1. Fact of Injury
    2. Causal Relationship
    3. Fitness for Duty

- Fact of Injury. One of the futies of the CE in determining a fact of injury is to make a judgment as to the time, place and manner in which the injury occurred. A CE makes that judgment based on information furnished by the claimant. When evidence in favor of an event happening is equal to the evidence against the event, "benefit of doubt" is extended. For example, a person submitting a Form CA-1 injury claim may include the following data:

    Data and Hour of Injury: 7/5/76
    Date of this NOTICE: 8/18/76
    Nature of Injury: Twisted left ankle

  The OS's report (reverse of Form CA-1) indicates the injury was reported on 8/13/76.

  Check the CA-1 to see if:

    a. Injury was reported immediately
    b. Medical care was obtained immediately
    c. Any witnesses were present, or
    d. There is a discrepancy in the statements of injury.

  A cursory look at the nature of the injury, the time the injury allegedly occurred and was reported to the OS creates some doubt to the validity of the claim in that (1) written notice was not given to the supervisor within 30 days as required by the Act and, (2) it appears an injury of this nature would create serious complications in much less time than indicated between the time it occurred and was reported. In this case, a CE is most likely to extend the "benefit of doubt". The claim is not denied at this point. Instead, a Form CA-1011 is sent to the claimant for additional information. The claimant must provide adequate information to support the

alleged injury since the "burden of proof" is their responsibility.

- Causal Relationship

The "benefit of doubt" enters into causal relationship in instances where complicated medical questions arise. In such instances an impartial specialist is acquired to resolve the question. If the specialist cannot resolve the problem, the "benefit of doubt" may be extended to the claimant.

Fitness for Duty - Weighing the Medical Evidence:

You will also be faced with the "benefit of doubt" concept when making determinations on "Fitness For Duty". The nature of the injury in some instances is such that this question can hardly be avoided. Cases involving "back" injuries (or any other injury that is of a complicated nature) almost always bring about a benefit of doubt.

A case of this type is submitted to the Medical Director for an opinion after all the facts have been gathered. Should it be returned and there is still a question regarding the medical opinion related to the claimant's fitness for duty, take the following actions:

1) Refer claim to third doctor for an opinion. If this doctor renders claimant "fit for duty" the conflict is resolved for the future, but not the past. "Benefit of Doubt" is extended to provide compensation for the claimant during the period it takes to make the decision.

2) If there is a conflict between the two (2) doctors, and their case histories are different to the extent that one doctor is considered more "reliable" than the other, than the one who is most reliable takes precedence over the other.

3) If both opinions (e.g., from two specialists) are of equal weight, then the CE makes the determination as to whether the claim is denied or accepted, after review by DMD.

4) The opinion of a physician assistance can be accepted as medical evidence if the evaluation or opinion is counter-signed by a physician.

In general:

- The probative value of the evidence determines the "weight" -- medical evidence with sound history and rationale carries more probative value that ME without rationale.

- Speculative evidence - Medical evidence based upon speculation or conjecture by the physician is NOT acceptable. The CE must obtain medical evidence with clear rationale.

. The opinion of a specialist usually weighs heavier than that of a non-specialist.

. The opinion of an attending physician (even a non-specialist) may weigh heavier than that of a physician who has not seen the claimant, i.e., your DMD.

"BURDEN of PROOF"

- "Burden of Proof" is a factor in making a decision to deny compensation. It occurs more in occupational disease cases than in those involving injuries.

- The responsibility for establishing merits of the claim belongs to the claimant. In so doing the claimant must do the following:

    1) gather the medical evidence needed to support the claim;
    2) identify all relevant factors of employment.

- In fact of injury cases, the claimant must submit all evidence concerning the occurrence of the injury except that information which is kept by agencies. In such instances, the CE acquires that information.

- When a claimant fails to provide the information (e.g., medical evidence with rationale) for which he/she is responsible, it is grounds for the CE to deny compensation, for the "burden of proof" is a responsibility of the claimant. However, once the CE accepts a claim for total disability, the "burden of proof" shifts to the CE to prove that the disability has lessened or ended, particularly on A/R cases.

ACTIONS to TAKE to RESOLVE CONFLICTS:

WHEN	THEN
- Claimant has not provided sufficient factual evidence on which to base medical opinion - Factual evidence is only circumstantial - "Benefit of doubt" is extended - Information is missing or incomplete	- Get specific additional information
- Factual evidence conflicts (e.g., facts vs. allegations) - The EA is unable to confirm or refute claimant allegations	- Specify questions that are unresolved and request investigation (Refer to Branch Chief; see Proc. Man. 1-8-110-1-8-112)
- Factual evidence is complete	- Write SOF
- CE cannot determine C/R on basis of medical opinion from attending physician - or in all occ. disease cases - Conflict of medical opinion	- Refer case to DMD with SOF
- Conflict of medical opinion from all physicians, including DMD	- Refer to impartial specialist

- When several alternative, but correct, approaches could be taken, consider which one would: cause less delay for claimant; create less time for the CE or OWCP; cost less money.

FACT OF INJURY

References:
- FECA 8101(5) - "Definitions"
- Procedure Manual, Chapter 1-800, Section 4, pp. 1-8-24 ff.
- Federal Personnel Manual (FPM), Chapter 810 3-2, under "Temporary Total Disability"
- FECA Program Memoranda series

The third "basic requirement" a claim must meet is "fact of injury". The question "Did an injury (or disease) in fact occur?" is often a judgment issue. If "fact of injury" (FOI) cannot be established, then the case can be thrown out (denied; a rarity when based only upon "fact of injury"). When FOI is established based upon factual evidence, then "casual relationship" becomes a serious consideration.

In determining "fact of injury", the Claims Examiner (CE) has to resolve two key issues:

1) Whether the "injury" is a traumatic injury, an occupational disease, or the aggravation of a pre-existing condition. ("Aggravation" will be covered in another part of the Resource Book.)

2) If it is traumatic injury, whether the incident being reported in fact occurred in the time, place and manner alleged.

INJURY vs. DISEASE

"Injury" is defined by FECA 8101(5) as: "includes, in addition to injury by accident, a disease proximately caused by the employment...."

TRAUMATIC INJURY is defined as: a wound or other condition of the body caused by external force, including stress or strain. The injury must

be identifiable as to time and place of occurrence and by member or function of the body affected; and be caused by a specific event or incident or series of events or incidents within a single day or work shift.

. FECA now provides, in the definition of "injury", for damage to and destruction of medical braces, artificial hands and other prosthetic devices or appliances (except eyeglasses and hearing aids). Prior to September 7, 1974, the damage to medical braces, artificial hands and other prosthetic devices was not compensable. These appliances will be replaced or repaired on a one time basis and the employee is entitled to continuation of pay (COP) while absent from work to have this done. Eye glasses and hearing aids may also be replaced or repaired if they were damaged incidental to a personal injury to the body that required medical attention.

. OCCUPATIONAL DISEASE or ILLNESS is distinguished from "traumatic injury" in that, in the former, exposure to environmental factors or agents in the environment is the critical issue. That is, while a traumatic injury is sort of a "one-shot deal", a "disease" is characterized by continued and repeated exposure to conditions of the work environment over a longer period of time.

- "Exposure" depends upon the type of case, for instance: hearing loss; TB; skin diseases (e.g., contact dermatitis); systemic infections; continued or repeated stress and strain or friction; exposure to chemicals, toxins, poison, smoke, fumes, silicosis or asbestosis, etc.

- For occupational disease cases, you need to establish the specific factors of the job in order to determine "fact of injury" due to exposure to environmental hazards or agents. That is, you must establish that the

claimant was, in fact, exposed to certain elements that (because of their amount, volume, density or duration) could cause an occupational disease. Further, there must be evidence that the disease exists (not just exposure to disease) when the claim is filed.

- To obtain additional factual information concerning the specific factors in the claimant's job and/or exposure to certain elements in the work environment, you would need to obtain medical collaboration by:
  1) Sending a CA-1020 to the Agency, with a copy to the claimant, and
  2) Sending a CA-1024 to the claimant with a copy to the Agency; except in case of hearing loss - send CA-1081 to Agency and CA-1082 to claimant, or other Hearing Loss (H/L) form letters, if used in your Office.

PROOF OF INJURY

When a claim is based upon a specific accidental (traumatic) injury, the "fact of injury" must be established by proof that event occurred by noting the time, place and circumstances of the injury.

. The "burden of proof" is on the employee to establish that he or she, in fact, sustained an injury in the time, place and manner alleged.

. The simplest kind of case (and an infrequent kind) is an injury claim in which the injury was witnessed and the claimant obtained immediate medical care and immediately reported the injury. (In fact, be leery of friends who are used as "eyewitnesses"!)

. "Fact of injury" can be established without having an eyewitness. When there is no eyewitness (or when the witness statement differs from the claimant's statements):

  1) Obtain, and carefully review, whatever factual and medical evidence that may be available. For example: claimant's statements; agency statements; statements from claimant's co-workers and supervisor;

any other agency-furnished information; attending physician's statements on the CA-16 or CA-20; hospital records; etc.

2) Look at the evidence to determine whether the behavior immediately following the injury is consistent with the alleged occurrence. That is, to what extent did the claimant "act hurt"? Some indicators of "acting hurt" would be:

- Did claimant mention the injury to anyone?
- Did claimant report the injury immediately?
- Did claimant use some home remedies prior to reporting the injury?
- Did claimant seek immediate medical care?

3) Statements relating to the "fact of injury" (e.g., how and why injury occurred, history of illness, etc.) should be consistent with other "surrounding facts and circumstances". Thus, look for conflicting statements in the evidence you received. Discrepancies in time, place and circumstance must be resolved before "fact of injury" can be established. (See also page 21 Resource.)

4) Factors (indicators of not "acting hurt") which may cast doubt on claimant's statements concerning "fact of injury" include:

- Inconsistencies occurred e.g., a medical injury occurred (e.g., a medical report with a history of injury at variance with CA-1).
- Failure to promptly report the injury (e.g., within 2 working days).
- Failure to seek immediate medical treatment (e.g., within a week).
- Continuing to work without apparent difficulty following the alleged injury.
- Failure to mention the injury to anyone.
- Possibility of a similar disability (or pre-existing condition) or injury having occurred prior to the alleged injury.
- History of injuries coming at the start of

3-day weekends, legal holidays, vacations, etc.
- Absence of witnessess to an event that reasonably could or should have been observed.

. When any of the following situations occur, or you need additional evidence to determine "fact of injury", send a CA-1011 to the claimant. In the event of major discrepancies in statements concerning "fact of injury", write a narrative letter to the claimant requesting more specific details (or "x" box 11 on the CA-1011, and write in this request) regarding the issues in question. Also, if a claimant is hospitalized, obtain the hospital records to verify or clarify the "history of injury or illness" given by the claimant.

1) Claimant did not report injury immediately.
2) Claimant did not get immediate medical care.
3) Claimant did not clearly describe how and why the injury happened, or claimant's statement reflects minor discrepancy with surrounding facts and circumstances.
4) Claimant didn't "act hurt" immediately following the alleged injury, and further explanation would help shed light on the situation.

. The claimant gets the "benefit of doubt" if the evidence leans in the claimant's direction or if the evidence in favor of an event happening is equal to the evidence against its happening.

Items to look at on the CA-1 or CA-2 to determine "fact of injury" are indicated on the following page.

To determine whether injury or disease, in fact, occurred - emphasis is on TIME, PLACE and CIRCUMSTANCES:

LOOK AT:		
CA-1, items	CA-2, items	SIGNIFICANCE
#9, #27	#12, #13	TIME (date and hour) when injury allegedly occurred
#10, #28	#32	Date of Notice of injury - was it reported immediately? (within 2 working days)
#8	#9	PLACE where injury occurred - was claimant on the job?
#13	#13	Cause of injury - how and why injury occurred.
#14	#15	Nature of injury - should be consistent with #13 and #17 on CA-1.
#17	-	Witness statement - what the witness saw, heard or knows - should be consistent with #13 and #14 on CA-1.
#41	-	O.S. knowledge of injury - should be consistent with #13 and #17 on CA-1.
#38	#29	Date claimant first obtained medical care - was it immediately or as soon as reasonably possible?

PERFORMANCE OF DUTY (POD)

References:
- FECA 8102
- Procedure Manual, Chapter 1-800, Section 5, pp. 1-8-28 ff.
- Larson's "Workmen's Compensation Law"
- Appeals Board decisions
  - Huber, 19 ECAB 147
  - Greenleigh, 23 ECAB 53
  - Joseph, 26 ECAB 134
- FECA Program Memoranda series

The determination of "performance of duty" is an issue that applies ONLY to traumatic injury claims. Basically, what you are trying to determine is that the incident resulting in an injury arose out of, and was in the performance of, the duties for which the employee was hired by the Federal Government.

The "performance of duty" question can be broken down generally into 2 main issues:

I. DID THE INJURY OCCUR ON-PREMISES?

- A. The "industrial premises" rule
- B. "Proximity Rule"
- C. To and from work
- D. Idiopathic falls

II. DID THE INJURY OCCUR IN THE LINE (PERFORMANCE) OF DUTY?

- A. Diversions from duty
- B. Statutory exclusions

The claimant is said to be "in performance of duty" (and therefore covered by the FECA) when BOTH issues can be answered affirmatively. If either issue is not acceptable, then it can be said that the injury did not occur in "performance of duty". The "burden of proof" is on the claimant to demonstrate that the injury occurred in the performance of duty.

I. DID THE INJURY OCCUR ON-PREMISES?

A. The "Industrial Premises" Rule: When an injury occurs on the premises of the employer during normal working hours, the employee is entitled to compensation benefits, even though the injury did not arise our of specific work. Additionally, implicit in this rule, an employee is usually covered for an injury that occurs on-premises:

- For a reasonable time (e.g., say, a half-hour) before and after work.

- While the employee is performing duties incidental to the job (e.g., getting coffee or food on break or lunch; getting a drink of water; going to the restroom; etc.) or performing an accepted practice of employment (e.g., obtaining supplies from a shelf; relaxing in an employee lounge, etc.)

The "industrial premises" rule works differently depending upon the claimant's "duty status", as follows:

1. EMPLOYEES WHO WORK FIXED HOURS IN A FIXED PLACE OF WORK.

a) If the injury occurs on the premises (e.g., property owned, operated or controlled by the federal government), then the claim is probably acceptable. If this criterion is met, you would then examine the second POD issue.

b) If the injury did not occur on the premises, then you need information from the Supervisor explaining why the employee was not on premises.

1. Legitimate duty (e.g., official government business or errands) off-premises is covered.

2. Off-premises lunches are not covered (unless the Agency has a written rule that forbids eating inside. Even if there is an unofficial policy that employees not eat at their desk and even if there are no lunch-room facilities on the premises, off-premises lunches are not covered).

2. EMPLOYEES WHO HAVE NO FIXED HOURS AND/OR NO FIXED PLACE OF WORK (e.g., letter carriers, fire fighters, police, etc.)

   a) If there is no deviation from the assigned route or duty (e.g., the route agreed to by prior arrangement with the supervisor), then the claim is probably acceptable.

   b) If there is a deviation from an assigned route (e.g., during a regular lunch on route), then an explanation is needed.

      1) Usually considered in POD to and from the route if employee leaves the route for a reason that benefits the Agency and is not purely personal in nature. (Refer to the Huber decision, 19 ECAB 147, 1967.)

   c) If the injury occurs while on-call or stand-by, then it is probably acceptable (even though one's "tour" of duty is over, and no matter how long the employee has been on-call).

   d) If the injury occurs while the person is not on-call, then you must determine whether the injury occurred during the normal scope of employment.

3. EMPLOYEES ON TDY ("temporary duty") - employees are staying in non-government quarters.

   a) Covered 24 hours a day for any activity reasonably incidental to the TDY. Examples: sightseeing; visits within a "short" distance (e.g., within a 50-mile radius or one hour away); injuries in a hotel, resturant, movies, etc.; recreational activities that could be expected when one is away from home (e.g., swimming in the hotel pool).

   b) "Rule of thumb" - covered if person is injured in the course of doing whatever the employee might normally do when on regular duty on-premises, or actions can be construed as those a "reasonably prudent individual" might take.

4. "BUNKHOUSE RULE" - employees are staying in government furnished housing (e.g., Cadets, Job Corps enrollees, VA, Public Health, Seamen, etc.)

   a) Covered for any activity reasonably incidental to performance of duty or during an accepted practice of employment.

   b) "Performance of duty" might include employees not working or not at their regular duty station (but not if they are at home). If an injury occurs at a place other than the regular duty station, get information from the O.S.

      1) Find out if the employee was participating in an activity authorized by, or under the direct supervision of an official superior.

      2) Find out if a pass was issued for an authorized activity or for claimant to visit a particular place.

      3) Find out if the pass contained restrictions or limitations relating to the activity permitted.

      4) Get an investigation report.

   c) Covered when the injury may be caused by living in close quarters, stress or friction.

   d) Job Corps enrollees are not covered for injuries that occur at their home, whether or not they are on a pass or on leave.

   e) Interpretation of the POD requirement is more liberally applied in the case of employees in social-type programs, such as Peace Corps or Job Corps.

NOTE: Employees are covered under the "bunkhouse rule" only if they are living in the government housing because of some requirement of the job or for the convenience of the employer.

B. "PROXIMITY RULE" (Procedure Manual, 1-8-37)

An employee who has a fixed place of employment generally is not in the POD when the injury occurs off the employer's premises. However, the "proximity rule" is an exception.

"Proximity rule" concerns those cases where the industrial premises are constructively extended to encompass a hazardous condition proximate to the premises, and considered to be hazardous of the employment, as distinquished from a hazard which is not peculiar to employer's premises.

C. TO AND FROM WORK - In general, FECA protection stops when the employee leaves the premises; the employee is usually not entitled to compensation for injuries sustained while going to and from work. The following are exceptions to the rule.

1. The employer furnishes the means of transportation. For example, the Postal Service provides for the carrier to use a postal vehicle and allows him or her to drive back and forth to work.

2. The employee is required to drive a vehicle while on official business. For example, rural carriers in some areas are required to use their own automobiles to deliver the mail. These employees are covered from the time they leave their residence until they return home again at the end of their tour.

3. The employee is on a stand-by call and is called back to duty. For example, a fire fighter, at home, is called in because of an emergency and is involved in an auto accident on the way to the employment site.

4. The employee is on official travel status (TDY). For example, an employee whose permanent station is located in New York City has been assigned to work in Washington, D.C. for a period of 30 days. The employee has coverage from the time he or she leaves the office or residence en route to the airport. This protection continues 24 hours a day until the temporary detail is concluded and the employee returns to New York City, either to his or her residence or office. The employee would lose protection of the FECA if only one of the specific statutory exclusions applies or if the employee were to deviate from the

general locale or temporary station. (For example, coverage would be suspended if the emplouee decided to go to Ocean City for the weekend. Coverage would stop when the employee departed from the metropolitan area of Washington, D.C. and would not be resumed until he or she returned to the temporary duty station hotel.)

5. The employee is taking home official government business (e.g., work must have been assigned by the O.S. - not just extra work taken home at the employee's initiative), or is called in by the Agency to work on a special assignment or project.

D. IDIOPATHIC FALLS - a fall caused by a personal condition (e.g., epilepsy, heart attack, diabetes, etc.) and not caused by an external object or factor (e.g., a slip or a trip).

1. Covered if: claimant hits something (e.g., desk) on the way down and/or the fall is "unexplained" (e.g., a faint or black-out; no known pre-existing condition)---the claimant is covered, but only for the results of the fall. For example, if the claimant has a pre-existing condition and passes out, hitting a drawer on the way down and resulting in a head injury, the claimant is covered only for the head injury and not for the pre-existing condition that caused the fall.

2. NOT Covered if: claimant hits the floor only and has an "explained" fall (e.g., has a pre-existing condition and the condition caused the fall).

Type of Fall	Explained	Unexplained
Hits Intervening Object	Covered	Covered
Does NOT hit intervening object	NOT Covered	Covered

II. DID THE INJURY OCCUR IN THE LINE OF DUTY?

The test of whether an injury occurs in the performance of duty is generall whether the injury arose out of and in the course of employment. The term "in the course of employment" means simply that the injury occurred while working. "Arising out of employment" means that there is "causal relationship" between a work experience and the injury. There are situations where an injury occurs in the course of an employment, but does not arise out of the employment. For example, a postmaster in a small town in Oklahoma filed a claim for acid burns on the face and loss of vision. This claim is based on an injury sustained by the postmaster while he was working at the stamp window. Someone came up to the window and threw acid in his face. Development of the factual evidence revealed that there was a personal relationship between the postmaster and the patron. Although the injury occurred during the course of employment, it actually arose out of a personal difficulty, not the employment. Therefore, the injury was not compensable under FECA.

There are injuries caused by certain activities which are absolutely NOT covered ("statutory exclusions") by the Act, and some which may or may not be covered, depending upon the type of diversion which resulted in an injury. The claimant's futy status (e.g., as listed under the "industrial premises" rule) is NOT a factor in determining whether the injury occurred in the line of duty.

A. DIVERSIONS FROM DUTY - There seem to be 6 major types of "diversions"; within each category, there are some "indicators" that suggest the resulting injury is usually covered or usually not covered.

1. Horseplay (e.g., "rough-house" or "kidding around")

a) Usually covered if:

1) Close or confining living quarters

2) Working together over a long period of time.

3) Long absences from home

4) Related to work environment (e.g., "playing aroung" while performing a job)

b) Rarely NOT covered, unless an "assault".

2. Assault

a) Usually covered if:

1. Accidental or random, or committed by an insane person for known reason, if employment causes the claimant to be at the particular place at the particular time of the assault.

2. Assault arises firectly out of employment factors - e.g., an attempt to rob the employee; or the assailant has a grievance against the claimant's Employing Agency.

b) Usually NOT covered if:

Assault arises out of personal matters unrelated to the job, and it cannot be shown that the assault was materially substantially aggravated by employment.

c) Actions to Take - Obtain (as appropriate):

- Police report concerning the incident
- EA report
- Witness statements
- Claimant's statement as to circumstances of the assault and events that led to it
- Statement from assailant

3. Recreational Activities (Procedure Manual, 1-8-32 - 1-8-33)

a) Usually covered if:

1) INFORMAL - employee is on premises during lunch or break (e.g., throwing frisbees)

2) FORMAL - an organized event that:

. Is part of the job (e.g., recreation with patients on premises)

. Agency derives a "tangible" or material benefit: the event meets Agency needs; the Agency contributes to the activity (e.g., offers space or financial support or time to participate); the Agency encourages participation in the activity.

Example: an Agency-sponsored team.

. Event usually occurs after hours.

To further identify a FORMAL activity, you need additional information as follows:

. Is participation as a player voluntary?
. Do employees who are members of the team receive their pay for playing?
. Are employees excused from regular assignments to play or practice during regular, scheduled work hours?
. Would refusal to participate operate against the employee in any manner with respect to his/her security of employment, advancement, etc.?
. Was the activity designed for the welfare, convenience, pleasure, or morale of the employees (usually not covered), or to meet a specific need of the employing establishment (usualoy covered)?
. What benefit did the employing Agency accrue by reason of the employee's participation in the event?
. Was the employee encouraged to join the team? By whom? How?
. Who played on the team?

b) Usually NOT covered if:

1) Recreational activity is not part of the job

2) Agency does NOT derive a "tangible" benefit (e.g., team softball after

hours or on Saturday, but not officially sanctioned or sponsored by the Agency)---Agency does not contribute to the activity or encourage participation; event is voluntary and for the employee's benefit.

3) Personal recreation off-premises on lunch or break (e.g., jogging).

4. Emergencies

a) Usually covered if:

1) Hostage

2) "Good Samaritan"

b) Rarely not covered

5. Personal Activities

a) Usually covered if:

. Permission is given by the Agency, AND injury arises out of factors of employment.

b) Usually NOT covered if:

. Permission is NOT given (or needed) by the Agency (e.g., running personal errands on lunch hour); or permission is given, but injury does NOT arise out of factors of employment. (See Joseph, 26 ECAB 134.)

6. Violations of a Safety Act

a) Usually covered if:

1) Rule is not stringently enforced
2) No warnings were given
3) Carelessness
4) Negligence (NOTE: Simple negligence is not a bar to compensation)

b) Usually NOT covered if:

1) Rule was stringently enforced
2) Claimant had frequent warnings
3) Intentional or deliberate negligence (e.g., refusing to wear safety equipment)---must be proved.

c) To DENY a claim due to intentional disobedience of a safety violation, you need solid evidence.

. Get evidence from the O.S. concerning:

1) The rule violated
2) How many times employee was told of the rule and manner informed.
3) How rule was enforced
4) Punishment, if any, for violating the rule.

. Get information from the claimant concerning:

1) Was he/she aware of the rule?
2) Was claimant told of the rule? How many times? How was claimant informed of the rule?
3) Reasons for violating the rule
4) Had he/she previously violated the rule? If so, what was the punishment, if any?

B. STATUTORY EXCLUSIONS - Difficult to prove; if proved, can NOT be covered under the Act.

Negligence and fault are immaterial in determining an employee's entitlement to benefits. The issue is whether the injury occurred in the course of employment and whether there is some relationship between the work and the injury. OWCP must consider all conditions of employment, not only the actual work performed, but also on-the-job training (OJT), administrative action, blood donations, inoculations, etc. In general, most activities occurring on the employer's premises are covered except for the following specific statutory exclusions from the Act:

1. Willful misconduct

2. Intoxication as a proximate (direct) cause of injury

3. The employee's intention to cause injury to himself/herself or another

If you decide to reject a case for one of these statutory exclusions, the burden of responsibility to prove the point shifts from the claimant to the examiner.

1. Willful misconduct is limited to a serious and deliberate violation of known regulations. Misconduct which results from carelessness, inadvertance, thoughtlessness, inattention, distraction or negligence does not come within the meaning of the term "willful misconduct". In most instances, "horseplay" (rough or boisterous play) and fights among co-workers do not constitute willful misconduct. These actions are a normal consequence to be expected when a group of workers are thrown into personal association for an extended period of time. Regardless of the circumstances surrounding horseplay or a fight, injury to an innocent victim is always compensable. (For example, injuries resulting from horseplay and fights are frequent among enrollees in the Job Corps and Youth Conservation Corps. The confining nature of the employment and long absences from home contribute to this problem. Horseplay is an expected element of the work environment in this case).

2. Intoxication is limited to whether the fact of intoxication was the proximate or direct cause of death, injury or disease. The fact of the employee's intoxication at the time of his death or injury is not necessarily a reason to exclude the claimant from compensation, if it can be shown not to be a proximate cause of the injury.

   The CE must have a medical report to prove intoxication. You need to know whether the alcoholic content in the blood ("blood ethanol content") was high enough that the injury was

caused directly (or solely) by the claimant's inebriated state, in order for the claim to meet the statutory exclusion.

3. Intent to cause injury to oneself or another is limited to deliberate and intentional acts and whether the employee was in full possession of his/her faculties. Although "intent" is difficult to prove, you need to get additional information concerning the claimant's intent and clarity of mind. You need to:

   a) Find out if the doctor believes the claimant is in full possession of his/her faculties, and what the claimant was doing prior to the injury.
   b) Ask the claimant about his/her activities prior to the injury and his/her intention that resulted in injury.
   c) Ask the CO-workers and Supervisor what the claimant's activities were prior to the injury.

A listing of items to look at on the CA-1 to determine POD follows on the next page.

TO DETERMINE "PERFORMANCE OF DUTY" - LOOK AT CA-1:

ITEMS	SIGNIFICANCE
#8	Where the injury occurred--on or off premises.
#9	Date/Hour of Injury - during working hours, regular work days, etc. Verify by looking at #27.
#12	Occupation - would this type of job result in the type of injury claimed?
#13	How/why injury occurred
#17	Witness statement - does witness state injury occurred in performance of duty?
#24, 26	Regular hours - did injury occur on duty, off duty, on call or stand-by?
#27	Date/Hour of Injury - should verify #9.
#35	OS answers specifically whether claimant was in POD at time of injury.
#36	Statutory exclusions - in opinion of the Agency.
#41, 42	OS concurrence with circumstances of the injury or additional explanation if indicated.

CAUSAL RELATIONSHIP

References: o Procedure Manual, Chapter 1-800, Section 6, pp. 1-8-48 ff. and Section 13, pp. 1-8-102 ff.

o FECA Program Memorandum 203

o Appeals Board decisions:

- Wilkinson, Docket No. 77-591

Determining causal relationship between a traumatic injury, disease or death and an individual's work can be very complex. The "burden of proof" is always on the claimant to the extent proof must be provided to establish "causal relationship". This is done by the C.E. who carefully determines the facts of the case from all pertinent medical records and evidence available.

There are four ways by which an injury or disease can be causally related to an employment situation, resulting in compensation. These are if the disease or injury is:

a. directly ("proximately") caused
b. precipitated
c. accelerated, or
d. aggravated

by an employment situation.

"PROXIMATELY CAUSED", as used in workers' compensation, usually is some condition of employment which, in a natural and continuous sequence, produces a disability. For example, a person who slips and falls and receives a broken arm or leg as a result of the fall, traumatic injury would be considered a direct result of the fall; therefore, it is directly caused.

In an occupational disease, the relationship is not as clear or simple. While a medical report is needed in both instances, in the latter situation because of the difficulty in substantiating the relationship, would require a detailed medical report clearly delineating the circumstances.

A precipitated, accelerated or aggravated injury or disease have one basic requirement in common - a pre-existing injury or disease exists. There need be no unusual or extraordinary conditions of employment to bring about an injury or disease. For example, work does not produce organic heart disease, but it can be proved to be a major contributing factor in "precipitating" a cardiac arrest.

An example of "acceleration" is the acting up of tuberculosis because of injury, exposure and the like. In this case a disease might have remained latent and inactive but for the employment.

o An "aggravation" of a pre-existing condition may be temporary or permanent.

Refer to: o FECA 8101 (5)
o Appeals Board decisions:
- Paul, 16 ECAB 464
- Armendo, 19 ECAB 27
- Maclaren, 19 ECAB 491

- To determine whether temporary or permanent - carefully review sound medical evidence.

- Temporary Aggravation

  o Results in no permanent damage -- employee returns to previous physical status.

  o Claimant is entitled to comp. ONLY for the period of temporary aggravation -- CE determines ending date by review of sound ME.

  o Claimant is not entitled to comp. for the underlying (pre-existing) disease.

  o ACTIONS TO TAKE to inform claimant of entitlement to benefits for temporary aggravation only:

    - Write narrative to claimant explaining that comp. can be paid only for the period of temporary aggravation and that underlying disease (unless job related) is not compensable.

    - Advise claimant to submit additional ME to establish whether underlying disease is job-related and/or that aggravation was longer than "temporary".

- Permanent Aggravation

  o Claimant is entitled to comp. for permanent aggravation.

On the next page is a chart which shows 4 categories of injuries and diseases, some typical causes, whether or not a particular case involving a certain injury/disease is usually accepted or not, the required supporting data, and actions to take.

CATEGORY	INJURY		DISEASE		
	SUPPORT DATA	ACTION	SUPPORT DATA	ACTION	AREA OF DIFFICULTY
Directly caused - no pre-existing condition is evident	MEDICAL REPORT supporting claim. STATEMENT of OS STATEMENT from Claimant	Usually accept- EX: Broken arm, leg sprains, cuts, etc.	Detailed medical report. Statement of OS. Previous medical history Statement from claimant	Relationship is not usually apparent. DO NOT accept. Request additional information from claimant, use Form Ltr. CA-1024	Relatively None
Precipitated - previous condition exists which is manifested by an employment condition Accelerated - previous condition exists which is hastened to deterioration by conditions of work Aggravated - pre-existing condition which, under normal conditions, does not interfere with work, but is aggravated by other than normal activity.	Detailed medical report, statement from O.S., and statement from claimant to provide: 1. History of injury 2. Conditions of work 3. Diagnosis 4. Medical opinion 5. Prognosis 6. Results of x-rays, lab, etc. 7. Received for medical care. 8. Physician's medical rationale for believing condition is caused by employment.	May accept or deny. Decision is made by CE. However, when data is questionable, disputed or conflicts, send case to Supervisor for a determination, especially if you feel claim should be denied EX: psychoneurosis (nervous breakdown due to stress of job) emphysemia (a lung collapsed due to exposure to toxic fumes) If insufficient information is available, send claimant Form CA-1024; send CA-1020 to agency.	Same as for "injury" If information received is insufficient, send forms CA-1020 to employing agency and CA-1024 to claimant. If case has been processed, and DMD reply received, and evidence is still too weak to establish causal relationship, send claimant letter stating reason for denial, or follow recommendation made by DMD.	Check for: Fraudulent Responses: 1. CA-1020 2. OS comment 3. Narrative Statement VA Disability: 1. Yes, request VA records 2. Other, have claimant acquire medical or hospital records. Resolvement of Causal Relationship: 1. Not resolved -prepare Statement of Facts (see Statement of Facts Chart)	Lack of Medical information - obtaining pre-employment physical data Resolving the relationship of disease to employment condition

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CONSEQUENTIAL INJURY/DISEASE

Consequential Injury. Consequential injuries can occur to the same or different member. A case in point would be an initial injury to a member which caused a disabling effect; later that disabling effect resulted in another injury, affecting the same member. The latter injury is the consequential injury. On the other hand, an injury to one member may indirectly affect a different member; i.e., the uninjured member may become impaired in some way due to an overuse of it in compensating for the injured member.

You will receive cases of this type which at the outset, the injury appears not to be related to the job. For example, a claimant with a knee injury may fall which results in a back injury. The claimant's consequential injury would be a "back injury". Consequential injuries seldom occur on the job; otherwise it would most likely be a new claim. A claim for this type of injury may be in letter form or on a CA-2a. In either instance, recognize and take the following action:

a) Ask claimant to explain in narrative the details of the second injury and give reasons why the second injury is connected to the first injury.

b) Ask claimant to furnish a medical report on the second injury to include the doctor's diagnosis, prognosis, and opinion on the causal relationship between the two injuries.

c) Develop a statement of facts for the new injury.

d) Send medical report and statement of facts concerning the second injury to the Medical Director for an opinion.

Consequential Disease. Consequential disease is defined in much the same way as a consequential injury. Simply put, it is a disease contracted by an employee that results in another serious disease. For example, a heart patient who takes a long period of time to convalesce, might go into a state of depression. The consequential disease would be "depression" (a consequence of the first). Procedures for handling these cases are the same as for those listed for consequential injury.

RECURRENCES

o DEFINITION

- Some injuries received on the job do not completely heal and, as a result, persons with them have recurrences from the old injuries. Persons with such injuries are eligible for additional compensation even though they have previously received compensation for the same injuries. Back injuries are commonly known to result in recurrences. Injuries of this type are often thought to be minor at time of occurrence, but later serious complications may develop. Claims for these injuries may not be received immediately.

- When, after returning to work, an injured employee is again disabled and stops work as a result of an increasing or worsening of the original injury or occupational disease, such disability is considered to be a recurrence. In these instances a Form CA-2a is required. If a new incident occurs, the matter should be treated as a new injury and Form CA-1 or 2, etc., submitted accordingly.

- The important thing to remember about "recurrences" is that no new injury has occurred, but that the claimant suffers an increase or worsening of the original disability. In this context, time (between the original injury or disease and the recurrence) is not a factor in determining whether the most recently reported injury/disease is a recurrence, as long as no new work factors are involved. ("Time" may be a factor in determining whether a claimant is entitled to a recurrent pay rate, however... see "Recurrent Pay Rates" in this Resource Book.) A claimant may have suffered a "recurrence" of the original injury if:

  ____ Claimant works full-time and has to return to light duty.

  ____ Claimant works light duty and becomes totally disabled.

  ____ Claimant's "partial" disability becomes a "total" disability.

  ____ Claimant receiving a Schedule Award has an increase in permanent impairment; may not have any time loss.

o When a Recurrence is Reported:

- Usually reported on:

(1) CA-2a - Notice of Recurrence of Disability

(2) CA-2a - Case transferred from another office, or

(3) Letter from claimant, if retired

- The following instructions should be observed:

o Form CA-2a should be submitted promptly by the Official Superior upon receiving notice that the employee has suffered a recurrence.

o If the original injury was not previously reported to OFEC, a report specifically covering the original injury should be made on Form CA-1 or 2 and attached when the CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.

o When the employee has received medical care as a result of the recurrence, a detailed medical report should be submitted by the attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between employee's condition and the original injury.

o If the employee was treated by other physicians after returning to work following his original injury, similar medical reports should be obtained from each.

o If the employee wished to claim compensation as a result of the recurrence and Form CA-4 or CA-7 was not submitted following the original injury, one should be submitted at this time. If a CA-4 or CA-7 was previously filed, compensation may be claimed by filing Form CA-8. A medical report on Form CA-20 (or in narrative form) must also be completed in accordance with the applicable instructions.

o If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Termination of Disability, should be forwarded when the employee returns to work.

- In the event the employee is not able to return to his/her same duties and suffers pay loss as a result of his/her disability, he/she may be entitled to additional compensation based on loss of wages or loss of wage earning capacity. (See also "Recurrent Pay Rates".) Upon notification of such loss, OFEC will advise the employee of the procedure to follow to claim additional compensation.

There is certain key information contained on the CA-2a. See chart.

Key Items	Significance	Action to Take
#8 - Date of original injury #9 - Date of Recurrence	Used to determine time span - date between original injury and date of recurrence	Determine if "short" or "long" period. 6 mos. or less considered "short" period. If 6 mos. or more, a statement from employee describing employee's duties & a general description of physical conditions during intervening period. If 2 yrs. or more, considered a "long" period, possible recurrence. Check medical and occupational history.
#10 - Date stop work	Indicates time some type of medical problem developed	Check to insure no new injuries have occurred.
#11 Date & Hour Pay stopped	Denotes if in LWOP status. Claimant will be concerned about pay date comp. begins	
#12 Pay Rate in effect	Indicates if eligible for recurrent pay rate.	If not received with CA-2a, send claimant Form CA-4 or CA-7.
#14 Date & Hour RTD	Indicates date and hour claimant returned to work following recurrence	

Key Items	Significance	Action to Take
#16 Date first received medical treatment	Indicates if claimant is currently working or has returned to work. Clue to severity of medical treatment	
#18 Handicapped after returning to work	Indicates extent of claimant's physical limitation	If not filled in, send claimant a letter for additional information.
#19 Description of disability circumstances	Describes the progress of claimant's condition	

- To Determine whether there is a Causal Relation between Recurrence and Original Injury:

  - Verify whether the original injury was likely to cause a permanent disability or some chronic ailment.

  - Obtain a medical report, if not submitted with claim

  - Determine length of time between original injury and alleged recurrence:

    - If less than 6 months"

      - OS can authorize medical care (CA-16)

      - Claimant may be entitled to remaining days of COP

      - CE generally accepts, contingent upon establishing causal relation based upon the medical report

    - If more than 6 months: Ask claimant to "bridge the gap" by requesting that claimant --

      a. Describe all medical care received for original injury to include name of doctor(s), dates of care between claim and last recurrence, and

      b. Describe all medical care for any other condition acquired during that time; describe nature/extent of any injury or disease.

      c. Give brief history of employment during intervening period:

         1. Job title
         2. Name and address of employer(s)
         3. Inclusive dates of employment
         4. Brief description of duties
         5. Gross weekly wages
         6. Reasons and dates for termination of employment, if applicable

      d. Provide reasons for believing current injury or disease is a recurrence of the original injury or disease

      e. Acquire medical reports (history and treatment) from all doctors who have treated him or her, if not in case file

      If appropriate, CE sends CA-1101 to CSC to determine whether claimant retired for disability.

- Obtain medical information and occupational history by drafting a letter to claimant requesting appropriate data. The "burden of proof" lies with claimant to provide pertinent information.

- When medical and occupational information is received, prepare SOF and send it with the medical report to DMD for an opinion.

- When a recurrence is approved, make the following entry in Item #56 of the Summary Sheet:

    - o Recurrence Date
    - o Initials
    - o Date recurrence is approved

- NOTE: The mere possibility of a recurrence is not a basis for payment of compensation. (Refer to Raymond Williams, 16 ECAB 418.)

STATEMENT OF FACTS

o Making "Findings of Fact":

- After all necessary evidence has been assembled, it is necessary for the Claims Examiner to make a proper determination of the claim. Questions of "causal relation" or "proximate cause" involve two kinds of determinations or findings, which can be classed as:

    1. Basic or evidentiary findings. A series of determinations on each fact that is material and responsive to the claimant's allegations concerning the accident or the working conditions. These determinations are the responsibility of the Claims Examiner and cannot be abdicated.

    2. Ultimate findings or conclusions: Whether there is "causal relation" or "proximate cause" between the basic findings and the disability. These are medical questions for which the Claims Examiner requires assistance from medical experts.

- The CE must make a "findings of fact" prior to accepting/denying a claim for compensation. (FECA 8124)

- The Statement of Facts (SOF) is a report of the evidentiary findings ("findings of fact").

- "FACT" - an observed, external event or circumstances:

    o Specific as to who, what, when, where, why, how

    o An event that exists or occurred

    o Not an allegation or subjective opinion or assessment; not judgmental by the claimant or OS

    o Refer also to Procedure Manual, 1-8-106 - 1-8-110.

- "Second adjudicator" - The Appeals Board has held that a CE cannot be second-guessed as long as he or she provides a sound rationale for facts accepted.

"FINDING OF FACT"	PURPOSE
Name of Employee	Identifies claimant
Name of Employer	Identifies claimant as Civil Employee
Date of injury or death	Identifies time of injury
Place of injury or death	Identifies place of injury
While in performance of duty	Places claimant in duty status
Circumstances surrounding injury	Brings out facts leading to injury
Nature of injury	Type of injury; parts of body involved; limits claim as to extent of injury
Extent of disability, if known	Period of disability; percent of disability or earning capacity; extent of liability
Birth dates of all beneficiaries (in death cases)	Establishes when minor children are to be removed from payroll
Facts of alienage	Basis for lump sum in event of non-residency
Average weekly wage	Basis for compensation rate
Timely notice and claim knowledge	Time limitation in Act
Other	Whatever may be in the issue

- Purpose of the SOF:

  A Statement of Facts is necessary in all cases where there is a need for an opinion from the OWCP Medical Advisor or from an impartial specialist. It is a series determinations ("findings of fact") made by the examiner on each of the allegations. These allegations refer to the injury sustained by the employee or factors of employment under which the employee is working. "Determinations" are decisions made by the examiner after sifting through the various allegations and counter-allegations of the employee and the agency to decide what is factual regarding an incident of injury or factors of employment (i.e., whether employee is under strain, pressures, deadlines, harassment, etc.) and so states this to be factual (i.e., the employee's job subjected him or her to considerable stress). The examiner should not just state "see employee's statement" or "the employee alleges"; rather, he or she should make a finding as indicated above. It is vital that the examiner make these determinations as they are the "frame of reference" (or history of injury) upon which the specialist or Medical Advisor is to base his or her opinions and conclusions. If the examiner abdicates this responsibility, he or she allows the Medical Advisor to, in fact, adjudicate the case.

  For opinions regarding causal relationship in disease cases or those traumatic injury cases where there is considerable time lag between the injury and the commencing date of disability, the statement should be more detailed than if the lag had not occurred.

- Writing the SOF:

  - The criterion for writing a SOF is that the information is adequate, concise and complete enough to get an effective, quick opinion from the DMD.

  - A Statement of Facts is made after all the evidence is gathered; it is submitted with the case to DMD (outline form has proven to be an effective format which permits the DMD to focus on the essential facts with a minimal amount of reading.) The SOF should be 1-2 pages only.

- The facts in the SOF should be:
    - o Correctly stated.
    - o Complete (contains all material facts).
    - o Unequivocal (e.g., something did occur)
    - o Specific (describe number of hours, size, weights, positions, etc.)
    - o Brief; clearly stated; unambiguous.
    - o Use positive terms.
    - o Logical sequence - chronological, if appropriate.
- Following is a chart which lists the information that must be included in the statement. Also included is the location of the information and actions to take.

STATEMENT OF FACTS
(SOF)

NECESSARY FACTS FOR PREPARATION	LOCATION OF INFORMATION	WHEN TO PREPARE	PITFALLS	ACTIONS	
				COMPLETION OF	RETURN OF
• Name of claimant • Case File No. • Employer • Date of Injury - Age - Length of service (if known) Brief description of duties and tour. • Nature of Injury • How injury occurred list events in chronological order • Prior Medical History - Miscelleanous Facts • Hobbies • Dual Employment • Smoking habits, etc.	• CA-1, CA-2, item 1 - Case File • CA-1, item 7, CA-2, item 8 • CA-1, item 9, CA-2, item 12 • CA-1, CA-2, item 2 • CA-2, item 38 • CA-1, item 14, CA-2, item 15 • CA-1, item 13, narrative by claimant. • Medical Reports - Claimant's statement - Claimant's statement •Claimant's statement -Claimant's statement	If causal relationship cannot be established or when a medical opinion is needed. Usually occur in occupational disease, recurrences consequential injuries Always write a SOF in disease cases.	Avoid judgments i.e."heavy box" Avoid generalities i.e."Lifted some boxes". Avoid opinions from OS, witnesses, claimant, etc. Avoid showing medical evidence; show only "nature of injury"	SEND case with SOF to OWCP Medical Advisor for opinion Send with memo or use CA-99.	Accept if - Medical Director indicates condition is causally related to work factors. Initial and Date, CA-800. Prepare to set up payment Deny if - DMD advises no causal relationship or lack of medical evidence to support causal relationship. Use impartial Specialist if Medical Directors opinion conflicts with attending doctor or conflicts with claimant's own physician. Send specific questions to DMD with a memo requesting impartial specialist to review case. Medical Branch makes arrangements for impartial specialist.

FORWARDING MEMORANDUM

After the Statement of Accepted Facts is made (See sample on pages 71-72, you are ready to prepare a list of questions for the Medical Advisor to answer Be specific and clear about what you want to know because in most instances the doctor will only respond to what you ask. The questions are prepared separately and sent with the Statement of Facts. (See sample, page 70).

Questions for medical opinion should include the following, when appropriate:

1) Whether the claimant has any employment related conditions precipitated, accelerated, aggravated or proximately (directly) caused. If aggravation: whether it is temporary or permanent. If temporary aggravation, request date of termination of disability.

2) If so, state all employment related diagnoses.

3) If the answer to #1 is yes; indicate whether the claimant has been disabled by reason of the employment related conditions.

4) If so, state whether the disability is for all gainful employment, indicating the date when total disability ceased and appropriate work limitations as of that date. For this purpose, a CA-815 should be attached to memorandum for completion by DMD. Or, if applicable, determine whether claimant had reached MMI, and if he/she has sustained any permanent partial impairment for S/A purposes.

5) Recommendations, if indicated.

SAMPLE: FORWARDING MEMORANDUM

File No. _____

Re: Kenneth Dowe

Doctor,

Your attention is directed to the STATEMENT OF ACCEPTED FACTS, attached, to be used as your frame of reference in furnishing a response to the following:

1. Diagnosis (es) of condition(s) found.
2. Relationship of the condition(s) to the accepted facts either on the basis of cause, aggravation, precipitation, or acceleration.
3. Rationale for the opinion(s) expressed.

SAMPLE SOF

Case File _____

Claimant: Kenneth Dowe

STATEMENT OF ACCEPTED FACTS:

1. Claimant was 52 yrs. of age at time of incident. Born 7/8/18.

2. He is a letter carrier for the Postal Service with 24 yrs. of service, working 8 hrs. per day, 40 hrs. per week, from 6:00 a.m. to 4 p.m.

3. He works in the Station setting up his route for approximately 3 hrs. per day and delivers mail for approximately 5 hrs. per day.

4. Setting-up entails securing first and second class mail from various points on the work floor and taking the mail to a cubby hole work table for sorting and slotting into cubby holes according to address. Slotting mail requires stretching arms length overhead, forward, and to each side. Cubby holes rise to a height of approximately 66 inches.

5. Claimant is 65½ inches tall.

6. Sorting and slotting first class mail requires approximately one hour, second class mail approximately 2 hours.

7. First class mail consists of letter size mail; second class mail and flats consists of magazines, newspapers both flat and rolled and mail in large and odd sized manila envelopes.

8. When sorting and slotting is completed, the mail is tied in bundles and placed in mail sacks for delivery to various feeder relay points along the carrier's route from which he can replenish his mail as he delivers.

9. On September 3, 1970, he reported for work at 6:00 a.m. He completed sorting the first class mail and was working on second class mail. He had returned with one armful of magazines and completed sorting them. He returned with a second armful and was in process of sorting this

second armful when he felt chest pains and numbness extending into both arms.

10. An ambulance was summoned, oxygen administered, claimant expired before he could be moved to a hospital.

11. No autopsy performed. No prior history of heart condition.

12. Carrier duties require excessive walking, climbing, bending, stooping, lifting and carrying. Carries weights up to 35 pounds in satchel on his shoulder; if he used mail cart, may push from 1 to 3 satches of mail; if drives vehicle, may be required to load and unload vehicle, lifting or dragging mail sacks weighing up to approximately 80 pounds. Works under all weather conditions.

The Postal Services considers carrier duties as being arduous and this office accepts it as such.

ACCEPTING OR DENYING A CLAIM

A claim is "accepted" for a specific injury if it meets all 5 basic requirements. This applies equally to controverted claims. However, keep in mind acceptance of a claim may not necessarily mean claimant is entitled to COP or compensation. An injury not reported within 30 days or if claimant is a member of a special agency, such as Peace Corps; either would be reason enough to deny entitlement of COP. For cases controverted by claimant's agency, see section "Controversion" on how to handle.

When a claim is accepted, the next step is to authorize COP or compensation.

Type	Accept	Deny
Traumatic Injury or Occupational Dosease	If 5 basic requirements are met: (1) Timely filed (2) Civil employee (3) Established fact of injury (4) Established Performance of Duty (5) Established causal relationship	If any one of the 5 basic requirements is not met.
	Initial, date and fill in condition on Summary Sheet. Advise O.S., doctor, attorney, as appropriate.	Send CA-1040 stating reason for denial, as long as there is only a CA-1 or CA-2 on file.
Hearing Loss - if denied because of absence of sound medical evidence, send CA-1083 to claimant.		Send Memo to Director and comp. order, when there is a CA-4, CA-7 or CA-8 on file.

CONTROVERSION

References:
- FECA 8118
- FPM, Chapter 810
- FECA Bulletin 47-74
- Federal Register, Vol. 40, #32, Part 3
- FECA Programs Memorandums, #188,191,233,252, 255,258
- FECA Circulars #79-23, 79-50

A. DEFINITIONS

- CONTROVERSION - means that the employing Agency, represented by the claimant's superior, decides to take issue with the claimant concerning the validity of his or her report of injury and consequent claim for continuation of pay as presented on Form CA-1, and thus to dispute and deny the claim. The word "controversion" means literally in Latin to "turn against".

- CONTROVERT - to dispute the validity of an employee's claim for COP.

- NON-CONTROVERT - to accept the validity of an employee's claim for COP.

- The term "controversion" applies ONLY to traumatic injuries occurring after 11/6/74.

- CONTINUATION OF PAY (COP) - continuation of an employee's wages or salary following an injury (from date disability begins).

  - COP differs from compensation in that COP is paid by the employing Agency; "compensation" is a benefit (either medical or monetary) paid by OWCP/FECA. Claimant may be entitled to COP or to compensation or to both.

  - An Agency must pay COP for the period of disability NOT TO EXCEED 45 days UNLESS the Agency controverts a claim for one of the 9 reasons for which it can legally stop pay.

- TRAUMATIC INJURY - For purposes of controversion, a "traumatic injury" is:

- A wound or other condition of the body, which is
- Caused by an external force, including stress or strain, and
  - Identifiable by time and place, and
  - Identifiable by member of the body affected, and
    - Caused by a specific event or incidence, or
    - Caused by a series of events or incidences,
    - Within a single day or work shift.

B. GENERAL PRINCIPLES OF CONTROVERSION:

o Controversion is the submission of a set of circumstances identified by the employing establishment which would operate against continuation of pay. This is the mechanical or administrative part of controversion. A general controversion would be based on disbelief or other factual information which would attack the merits of the case as presented by the claimant.

o The reasons for an Agency's controversion MUST be SPECIFIC to the case at hand.

- Far too many controversions by employing agencies are subjective in nature, and are not supported by objective evidence. The supervisor may feel, for example, that the allegation by the claimant that he or she was injured while on duty may reflect on the Supervisor personally and on his or her ability to run a "safe" operation. The Supervisor may therefore resent the claimant and decide to try to cast doubt on the credibility of the claimant by controverting his or her claim, even though the Supervisor doesn't really have any solid grounds for doing so. The Supervisor should by no means be discouraged from controverting claims, but he or she should be advised to make the case effective by presenting solid, objective facts.

- If the supervisor wishes to demonstrate willful misconduct or negligence on the part of the claimant, he or she must show intent by the claimant to conduct himself or herself improperly or to be negligent.

o In most cases, the Agency must continue pay unless or until told differently by the Claims Examiner.

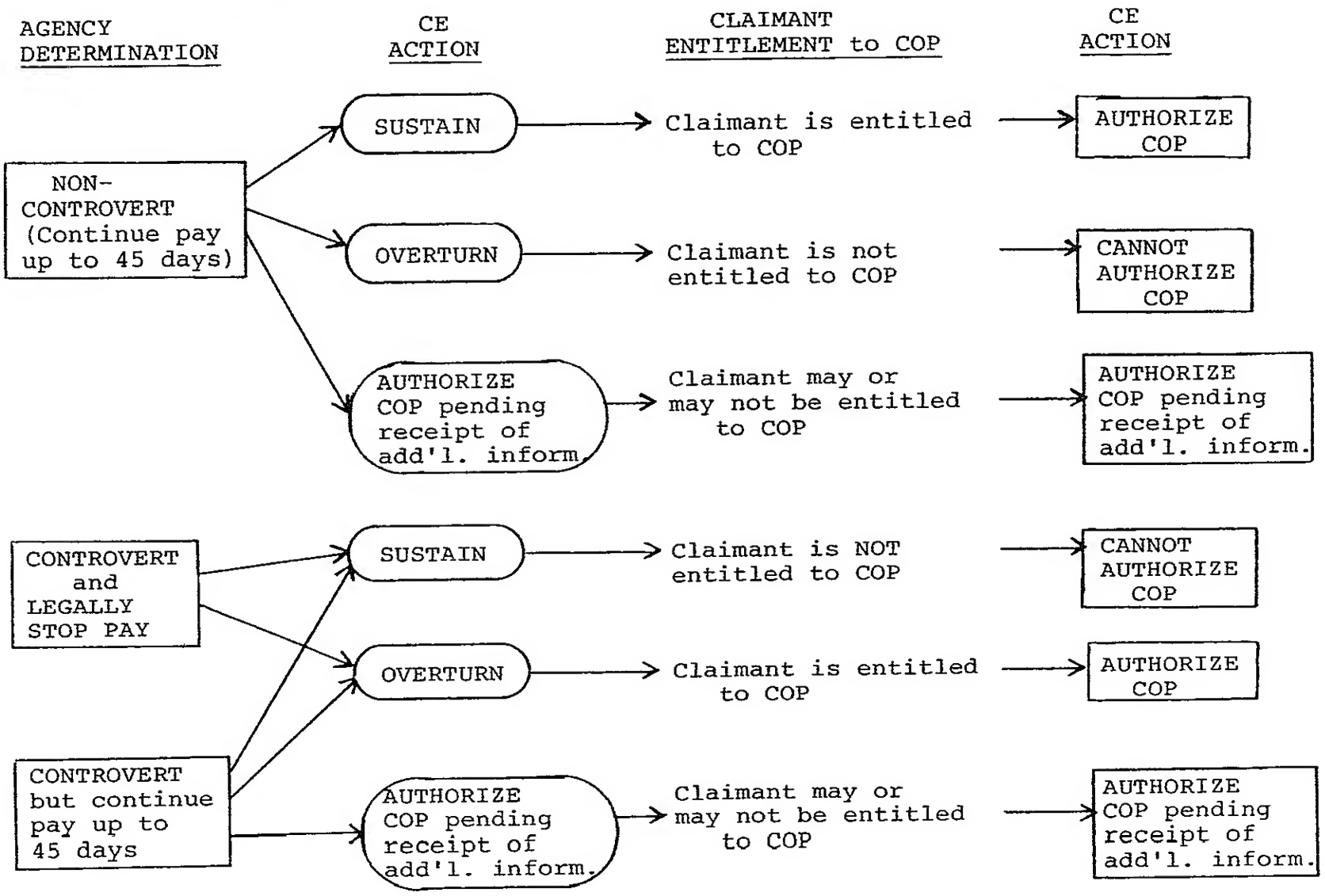
- The CE has 3 actions to take concerning the Agency's determination of the validity of a claim for COP:

  - SUSTAIN : to agree with the Agency's determination

  - OVERTURN : to disagree with the Agency's determination

  - "NOTHING" : to authorize the continuation of COP pending receipt of additional information.

CONTROVERSION and AUTHORIZING COP (OVERVIEW)



AGENCY DETERMINATIONS

AGENCY OPTIONS	REASONS	LOOK AT CA-1 ITEMS	FREQUENCY OF OCCURRENCE
NON-CONTROVERT Agency will continue pay (COP) up to 45 days	.No reason to dispute validity of claim	#41, 42	Most Typical
CONTROVERT and LEGALLY STOP PAY	.Regulatory Exclusions for which Agency can legally stop pay:	#42	
	1) Injury not reported within 30 days after DOI.	#9, 10, 27 28	Most frequent
	2) Injury is occupational disease or illness	#4, 8, 9, 13, 35, 42	Frequent
	3) Work stoppage first occurred 6 months or more following injury	#9, 27, 29, 42	Frequent
	4) Injury occurred off-premises and claimant NOT involved in off-premise duties	#8, 9, 35, 42	Occasional
	5) Volunteers, contract employees, consultants	#7, 12, 42	Infrequent
	6) FECA statutory exclu-clusions: willful mis-conduct, intoxication or intent to injure self or others	#36, 42	Unusual
	7) Claimant reports injury after his/her employment has terminated	#42, 9, 10, 28	Unusual
	8) Claimant is a Job Corps enrollee, or in Youth Conservation Corps (YCC), VISTA, Peace Corps, Civil Air Patrol, etc.	#7, 12, 21, 22, 23, 35, 42	Highly unusual
	9) Employee is not citizen or resident of U.S. or territories	#42	Highly unusual

AGENCY OPTIONS	REASONS	FREQUENCY OF OCCURRENCE
CONTROVERT, but continue pay (COP) for 45 days	.One of the 5 basic requirements is NOT met (usually concerns "fact of injury", or performance of duty, or problems with medical evidence re causal relationship)- EXCEPT, if 30-day time requirement is not met, Agency can LEGALLY stop pay.	Frequent
	.Questions concerning: -Claimant's "Fitness for duty"	Most Frequent
	-"Fact of injury", e.g., where claimant may have "faked" injury, or delay in reporting injury (e.g., filed within 30-day time limit, but not reported immediately)	Frequent
	-Causal relationship, e.g., when Agency does not feel there is a causal relationship between described employment activity and the medical condition.	Frequent

FORMS RELATED TO "CONTROVERSION"

FORM	WHEN USED	SIGNIFICANCE
CA-1	.Always in traumatic injury cases	.CE must have CA-1 or form approved by Sec. of Labor to make decision to SUSTAIN/OVERTURN the Agency's determination.
CA-16: FRONT ("Authorization for Medical Care")	.Issued by Agency .Authorizes FEC to pay claim regardless of claim decision.	.If front of CA-16 is not filled in, CA-16 is not a legal document.
CA-16: BACK ("Medical Report Form")	.Completed by doctor, and for statement of charges.	.Provides medical evidence related to controversion-compare medical history on CA-1 and CA-16 for collaboration: -Relates to "Fitness for duty" - items #29, 30, 31, 32 -If item #15 on CA-16 is at variance with CA-1 history of injury, there might be grounds to "controvert" -If item #19 on CA-16 is checked "No", there may be a problem with causal relationship. -If CA-16 arrives before CA-1, case can be started (but CE still needs CA-1 to make "controversion" decision)

ACTIONS TO TAKE WHEN THE AGENCY "NON-CONTROVERTS"

CE DECISION	REASONS	CE ACTIONS
SUSTAIN (claimant is entitled to COP)	.No reason to dispute Agency decision	.Accept case
	.Question concerning "Fitness for duty", but CE has medical evidence and it is not sufficient to OVERTURN	.Accept case
	.Question concerning "delay in filing claim" but: -no debate about "Fact of injury" (e.g., witnesses or Agency took time to review form) -claimant sought help immediately -claimant was in hospital -Agency is unfamiliar with injury claims	.Accept case
OVERTURN (claimant is <u>not</u> entitled to COP)	.Any of the 3 statutory exclusions under FECA .Any of the 9 regulatory exclusions for which Agency can legally stop pay .Need to ascertain 30-day time limit (check CA-1, #9, 10) .Medical evidence sent to O.S. (check item #40) does not support claim of disability for work .Correct form not used: need to verify injury (CA-1, #13, 14) .Occupational disease (check Ca-1, items #8, 9, 13, 14)-not entitled to COP	.Send CA-1050 to claimant, copy to Agency, <u>after</u> memo to Director

ACTIONS TO TAKE WHEN THE AGENCY "NON-CONTROVERTS"

CE DECISION	REASONS	CE ACTIONS
Authorize COP pending receipt of additional information	.Lack of medical evidence, or medical evidence is insufficient to make a determination at this point (concerning claimant's disability for work) .Injury so minor that (even without medical evidence) it is unlikely that it would disable claimant from doing his/her job.	.Send CA-1038, check Box 2, and request medical report (unless claimant is out less than 1 week)

ACTIONS TO TAKE WHEN THE AGENCY "CONTROVERTS"

CE DECISION	REASONS	CE ACTIONS
SUSTAIN (claimant is not entitled to COP)	.Any of the 9 regulatory exclusions for which the Agency can LEGALLY stop pay.	.Send CA-1050 Memo to Director
	.Information requested in doubtful situations is received and you now agree claimant is not entitled to COP	.Send CA-1050 Memo to Director
OVERTURN (claimant is entitled to COP)	.Claimant "abuses" sick leave, or is "accident prone", or is not following safety rules --when this decision is based upon Agency's characterization of claimant and unless there is better evidence because: -The controversion is NOT specific to this injury and CE cannot rely on unsupported allegations about claimant's "moral" character	.Send CA-1038, check Box 1; or check Box 2 if you need information of a medical nature
	.No rational basis for the controversion (e.g., appears to be a solid case in spite of "controvert", such as a rational reason for delay in reporting injury) and you have supporting medical evidence	.Send CA-1038, check Box 1
	.Information requested in doubtful situations (e.g., those in which you originally authorized continuation of COP pending additional information) is returned and is acceptable	.Send CA-1038, check Box 1

ACTIONS TO TAKE WHEN THE AGENCY "CONTROVERTS"

CE DECISION	REASONS	CE ACTIONS
Authorize COP pending receipt of additional information	.Question concerning "delay in reporting injury" and (any of the following): -beyond"reasonable" delay of 2-3 days -no witnesses -claimant did not seek immediate medical help	.Send CA-1038, check Box 2 to further investigate .Send CA-1011 to claimant to explain delay, check appropriate Boxes 2-10.
	.Medical evidence does not support contention of "Not fit for duty"	.Send CA-1038, check Box 2 for medical evidence; CA-1050
	.Agency does not feel there is a causal relationship and makes a sound case.	.Send CA-1050
	.Agency does not feel there is a causal relationship, but medical evidence supports causal relationship AND Agency reasoning is of dubious nature or is not specific to case at hand.	.Send CA-1038, check Box 1
	.Agency is aware of pre-existing condition (e.g., old football injury) which may preclude claim as an "injury"	.Send CA-1038, check Box 2; request additional evidence about pre-existing condition; Box 1 if you have no evidence from Agency about the condition or allegation is vague.

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ACTIONS TO TAKE WHEN THE AGENCY "CONTROVERTS"

CE DECISION	REASONS	CE ACTIONS
Authorize COP	.Alleged recurrence, BUT evidence indicates it is, in fact, a new injury	.Send CA-1038, check Box 1
Authorize COP pending receipt of additional information	.Diagnosis not compatible with injury (e.g., back injury vs. arthritis, or tripped bs. fainting spell), or major discrepancy in HOW injury occurred.	.Send CA-1038, check Box 2 .Request additional information from claimant and/or O.S. and/or doctor and/or witnesses to clarify discrepancies or diagnosis

U.S DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

File No.:
Date of Injury:
Employee:

Noncontroverted ☐ Controverted ☐

We have received Form CA-1 reporting an injury and your agency's response to the evidence submitted. It has been determined that:

☐ 1. The facts of the injury and employment support the employee's contention that he/she was a Federal employee who sustained a traumatic disabling injury in the performance of duty. You should, therefore, continue his/her pay for the period of disability not to exceed 45 days.

☐ 2. The information of record is insufficient to make a decision on the case; however, you should continue the employee's pay without interruption. Additional information is required as noted on the reverse of this letter.

☐ 3.

Sincerely,

Supervisory Claims Examiner

Include your address, ZIP code, and file number on all correspondence

Ltr. CA-1038
Rev. Apr. 1977

CONTROVERSION AND ENTITLEMENT TO COP:

AGENCY DETERMINATION	CE ACTION	SIGNIFICANCE OF CE ACTION
NON-CONTROVERT	.SUSTAIN	.Claimant is entitled to COP .CE can authorize continuation of COP
	.OVERTURN	.Claimant is not entitled to COP .CE cannot authorize continuation of pay
	.NOTHING	.Claimant may or may not be entitled to COP .CE can authorize continuation of COP pending receipt of additional information.
CONTROVERT AND LEGALLY STOP PAY	.SUSTAIN	.Claimant is not entitled to COP because one of the 9 regulatory exclusions is evident .CE cannot authorize COP
	.OVERTURN	.Claimant is entitled to COP if none of the 9 regulatory exclusions is evident .CE can authorize COP
CONTROVERT, but CONTINUE PAY	.SUSTAIN	.Claimant is not entitled to COP. .CE cannot authorize continuation of COP
	.OVERTURN	.Claimant is entitled to COP .CE can authorize continuation of COP
	.NOTHING	.Claimant may or may not be entitled to COP .CE can authorize continuation of COP pending receipt of additional information

CONTINUATION OF PAY (COP)

Reference:
- FECA 8118
- FECA Release 80-39
- FPM, Chapter 810, pp. 5-9

A. GENERAL PRINCIPLES OF COP

- "Continuation of Pay" (COP) is the employing Agency's continuation of a claimant's pay (wage or salary) from the Date Disability Begins (DDB).

- COP is directly related to the issue of "controversion" and applies only to traumatic injury cases.

- COP is paid by the employing Agency, until or unless it is not authorized by the Claims Examiner. It differs from "compensation", which is a benefit paid by FECA. A claimant may be entitled to COP and/or to compensation.

- An Agency must pay COP for a period NOT TO EXCEED 45 CALENDAR DAYS UNLESS the Agency controverts a claim (and the controversion is sustained) for one of the 9 statutory reasons it can legally stop pay.

- The "45 days" starts from the Date Disability Begins (DDB), (except on DOI, if disability is immediate and part of a work day or shift has been worked.)

- When the 45 days are used consecutively, the 45 days are counted on a calendar day basis (counting Saturday and Sundays), UNLESS claimant returns to work on a Monday (or the day after "normal" days off), in which case Saturdays and Sundays don't count.

- If claimant uses part of a day, it counts as one day.

- Usually, the day on which the injury occurs the claimant gets "administrative leave"; (except on DOI, if disability is immediate and part of a work day or shift has been worked), in that event, the DDB would be the day after the DOI.

- Claimant may elect to use sick leave or annual leave.

  - If claimant elects to use sick or annual leave, the time is subtracted from the "45 days". However, claimant may (upon request to the employing agency) change the election in favor of COP during the 45-day period. The decision to "buy-back" this leave in favor of COP is the employing Agencies to make.

- The employing agency cannot without the employee's authorization, substitute leave or LWOP for COP once the claim has been approved by OWCP.

- The CE should be wary of an Agency's pressuring an employee to use sick or annual leave (e.g., note if the CA-1, item #16, has been erased or altered).

o COP can be paid for 45 days or until claimant returns to work ("duty"), whichever comes first. When COP expires, OWCP will pay compensation for the first 15 days immediately following the expiration of the 45-day COP period prior to receipt of CA-7 (traumatic injury). Then claimant must put in a claim for compensation, by submitting a CA-4 (if disease) or CA-7 (if injury).

o RECURRENCES (FPM, Chap. 810, 5-8 (1).)

- When a recurrent disability begins LESS THAN 6 months after the first return to duty, COP is to be continued for the duration of the period of disability or the remainder of the 45 days, whichever occurs first. The beginning date of the period of disability is the criterion for paying COP. Thus, in the event of a recurrence, COP can be paid beyond the 6-months (after first RTD), so long as the absence is continuous and an aggregate of 45 days COP has not been used. (From a policy statement issued 3/17/78).

  Example:
  - DDB is 2/8
  - RTD is 2/20; used 11 days of COP.
  - 6-month period after first RTD ends 8/20.
  - Recurrence happens 8/19 -- claimant is entitled to 34 days of COP provided there is continuous disability from 8/19 through the entire 34-day period.

- When a recurrent disability begins MORE THAN 6 MONTHS after first return to duty, claimant is no longer entitled to COP, even if some of the 45 days may be unused. Claimant must put in a claim for compensation.

o A claim may be "accepted" for a specific injury (e.g., all 5 basic requirements are met), but not necessarily be entitled to COP or to compensation.

- It is the CE's job to authorize the continuation of pay (COP) once the Agency has started COP from the

Date Disability Begins (DDB).

- It is possible that you can "accept" the case (e.g., the 5 basic requirements are met), but not authorize the COP. For example:

  a) You can accept that the injury, in fact, occurred but that the injury was not a disabling one (e.g., the person should have returned to work)...then, COP should not be authorized.

  b) You can accept that the injury, in fact, occurred but, if the claimant is "fit for light duty" and the Agency had light duty available and did not return to work, then COP should not be authorized, unless the Agency has no light duty available for the claimant.

B. AUTHORIZING COP AND ACTIONS TO TAKE

o CE can AUTHORIZE COP when:

- Claim is for traumatic injury

- None of the 9 regulatory exclusions (for which an Agency can legally stop pay) applies.

. ACTIONS TO TAKE: Send CA-1038 to Agency (copy to claimant), check Box 1, which authorizes Agency to continue the COP. (Done only: 1) if OWCP overturns controversion by Agency; 2) if Agency specifically requests same.) Attach copy of Privacy Act (CA-104).

. On CA-800: record "COP", initial and date in block #57; in block #58, record "CA-104 released" and date.

o CE CANNOT AUTHORIZE COP when:

- Not a traumatic injury (as defined under "controversion")

- Not a disabling injury (too minor to disable claimant for work)

- No medical evidence to support injury is sent to the O.S., or medical evidence does not support disability for work.

- One of the 9 regulatory exclusions for which Agency can legally stop pay:

o ACTIONS TO TAKE:

- Send CA-1050 and Memo to the Director: denies COP only; tells claimant why COP was not authorized and advises claimant of his/her rights under FECA.

- Send CA-1040: informal denial of the claim; send only if the whole case is "no good" (e.g., you can deny the claim because one of the 5 basic requirements is not met and claimant is not entitled to COP), and if there is only a CA-1 (but not a CA-4 or CA-7) on file. Note that, if the claimant has a "good" case (e.g., you could "accept" it because all 5 basic requirements were met), but COP cannot be authorized, then you would send the CA-1050.

TO DETERMINE WHETHER TO AUTHORIZE COP, LOOK at the CA-1:

Items	SIGNIFICANCE
#7, #12	.Where the claimant worked when injured and occupation; some types of employees are not entitled to COP (statutory exclusion)
#9, #10, #27	.If notice not filed within 30 days of injury, not entitled to COP
#12	.Offers clue of whether type of injury claimed could have occurred.
#13, #14, #38, #40	.Cause and nature of injury affect "performance of duty" issue; if medical evidence does not support disability for work (#40), COP cannot be authorized.
#16	.Indicates whether claim is for leave or COP; also, claim must be signed
#17	.Witness statement should collaborate claimant's statement
#26	.Clue to whether injury occurred on day claimant was not supposed to be working
#29	.If claimant stopped work more than 6 months after injury (#9, 27), then COP cannot be authorized
#30, #31	.Shows whether pay has been terminated or when Agency started COP
#33	.Important later, when considering recurrent pay rate
#35	.If claimant was not in "performance of duty", COP cannot be authorized
#36	.If "Yes", further investigation is necessary; COP cannot be authorized.
#41	.If O.S. statement conflicts with claimant, need additional information
#42	.CE has 3 options in response to Agency determination

OTHER FORMS RELATED TO COP

FORM	WHEN USED	SIGNIFICANCE
CA-16	.FRONT - completed by Agency .BACK - completed by doctor	.Provides medical evidence related to controversion - compare to medical history on CA-1, especially: -"Fitness for duty" - if medical evidence does not support disability for work, COP cannot be authorized. -If medical evidence does not support the cause or nature of injury, COP cannot be authorized.
CA-3	"Report of Termination of Disability and/or Payment" - submitted after the 45 days of COP have expired	.Indicates when claimant returned to duty
CA-7	"Claim for Compensation" - submitted when the 45 days of COP expires, OR if claimant is not eligible for COP	

DETERMINING ENTITLEMENT TO COMPENSATION

Entitlement to Compensation

- After a claim has been evaluated and can be accepted for a specific injury or disease, the CE next determines whether or not to accept the claim for COP or for compensation.
  - If you can determine entitlement based upon information provided, then you determine to what type of compensation claimant is entitled.
  - If you can't determine entitlement based upon information given, then you need to specify and obtain additional information to make the determination.
- To accept or deny a claim, the following must be evident:

ACCEPT	DENY
LWOP status and medical evidence supports disability	No disability for work
Suffered permanent impairment to schedule member	No permanent disability to schedule member
Suffered serious disfigurement to head, face or neck	No disfigurement
Loss of wage earning capacity and medical evidence is supportive	No LWEC - disability does not prevent person from earning comparable wages

DETERMINING ENTITLEMENT

There will be instances wherein a claim will not have sufficient information for the CE to make a determination. When this happens the CE will have to acquire additional information. Some of the most common is medical evidence.

- TTD. Normally a request for additional payroll information for this type of compensation can be done either by telephone or letter. If medical report is missing, obtain it by letter. You'll need it to determine extent of disability.

- Schedule Award. If medical evidence is lacking, before a complete determination can be made to award this type of compensation, a CE must do the following:

    - o Send claimant to attending doctor for medical evaluation.

    - o Send CA-1311 to claimant and CA-1303 to attending doctor.

    - o When medical report is received, send CA-99 to District Medical Director for an opinion on the degree of disability established.

- LWEC. For compensation to be approved for a LWEC claim, medical evidence must be available to support the fact that the claimant cannot perform former job, or earn comparable wages; but, still can be gainfully employed. If medical evidence is lacking in this regard, you'll need to:

    - o Obtain copy of claimant's work tolerance limitations. Send CA-1311 to claimant and 1316 to doctor. (When medical evidence has been received then ask supervisor for guidance.)

- Disfigurement. Send application for disfigurement award CA-1094 if not already on file. Discourage minor facial scratches. In a disfigurement claim, certain background information is needed in addition to medical evidence before a determination for compensation can be approved.

    - o Background Information required:

        - o Age
        - o Sex
        - o Education
        - o Job
        - o Hobby

Check to see if Form CA-1653, 1051, or 1037 is on file. If not, send a CA-1037 to claimant for completion and return. When form is returned and all evidence is in, set up an appointment with the nearest District Office for the claimant. All claimants for disfigurement must be interviewed to see if the disfigurement really exists.

▷ TYPES OF COMPENSATION

The following chart illustrates the types of compensation and the evidence required to support each type.

Type	Criteria for Eligibility	Location
TTD (temporary total disability)	Claimant in LWOP status & is disabled; medical and factual evidence supports total disability.*	CA-4, item 4 and 18; CA-7 items 7,18,19 & 25; medical report.
Schedule Award (See S/A Chart, p. 98)	Injury of schedule member or internal organ & Permanent Disability (member can't be returned to its original condition - a medical decision)	CA-4, item 4; CA-7, item 5; Schedule Award chart or see 8107 FECA Medical Report
	Date of Maximum Medical Improvement has been reached (Marie J. Born, 27 ECAB 623, 1976.)	Medical Report
LWEC (loss of wage-earning capacity)	Permanent partial disability & claimant can't earn comparable wages	CA-4, item 4; CA-7, #5; Medical Report; CA-4, items 15 & 27; CA-7 items 19 & 34
Disfigurement award	Suffered permanent disfigurement to head, face or neck. Two photos of area required.	CA-4 CA-7 Letter Medical Report CA-1094

*NOTE: The doctor determines impairment; the CE determines disability.

- o Works after 6:00 pm - entitled to night differential.

- o Routinely works holidays - entitled to holiday pay.

3) If claimant is entitled to PREMIUM pay, send a CA-1003 ("x" Box 7) to the Agency to request the gross amount of premium pay earned by claimant for the one year prior to injury, recurrence or disability.

   - Fill in the dates for which premium pay is desired.

   - If more than one type of premium pay is involved, ask the Agency to list each separately.

4) No matter how the Agency submits a claimant's pay rate (e.g., annual, weekly, bi-weekly, hourly), the CE must arrive at a TOTAL WEEKLY Pay Rate.

   - Calculate the weekly base pay rate.

   - Calculate the weekly premium pay rate.

Weekly base pay	+	weekly premium pay	=	TOTAL WEEKLY PAY RATE
($130)	+	($20)	=	($150)

TO DETERMINE TOTAL WEEKLY COMP. RATE:

1) Determine whether claimant is entitled to augmented compensation.

   - Look at CA-4 (item #10) or CA-7 (item #13) to determine whether claimant has dependents.

     - o Yes, dependents - Comp. Rate = 3/4 of total weekly pay rate

     - o No dependents - Comp. Rate = 2/3 of total weekly pay rate

   - If it is unknown that claimant has dependents,

pay at 2/3, and increase if necessary later.

2) Determine whether claimant is entitled to CPI - effective date of pay rate and disability for work must be at least one year. (That is, the "Effective Date of Compensable Disability" must be at least one year.) NOTE: Entitlement and computation of CPI's applies similarly to adjustments, hearing loss, dual benefits or recurrences.

   a) Check the Date of Disability (first date comp. or COP or leave is being paid).

   b) Add one full year to that date.

   c) Check the CPI Book to see if there is any CPI effective AFTER the one full year.

      1) Claimant is entitled to all CPI's in effect after the one full year.

      2) Claimant is not entitled to a CPI if the effective date of disability is LESS THAN one full year before the date of the most current CPI.

Entitled to CPI	Not Entitled to CPI
DOD = 4/1/76 Add 1 year = 4/1/77 New CPI = 7/1/77	DOD =10/12/76 Add 1 year = 10/12/77 New CPI = 7/1/77
More than 1 full year has elapsed; claimant is entitled to all CPI's after 4/1/77	Less than 1 full year has elapsed since DOD; claimant would not be entitled to any CPI's until after 10/12/77

3) Determine total weekly comp. rate (TOTAL COMP.):

When no CPI is involved, TOTAL COMP. equals:

Total Weekly Pay Rate (A) x Comp. Rate (B) = Wkly.Comp. Rate (C)
($150) x (3/4) = $100.00

When a CPI is involved, TOTAL COMP. equals:

Step 1 - Total Weekly Pay Rate (A) x Comp. Rate (B) = Wkly Comp. Rate (C)

///

Step 2 - Wkly. Comp. Rate (C) x CPI (D) = increment (E)

Step 3 - Increment (E) + "old" wkly Comp Rate (C) = "New" Wkly Comp. Rate

Step 4 - Round "new" Wkly Comp. Rate to nearest 25¢ = TOTAL COMP.

(A x B)	= (C)	x (D)	= (E)	+ (C)	= New wkly Comp.
($150 x 2/3)	= ($100)	x (.042)	= ($4.20)	+ ($100)	= $104.20

Total Weekly Comp. = $104.25 (the "new" weekly comp. rate rounded to nearest 25¢)

NOTE concerning "COLA's":

- The "COLA" (cost-of-living adjustment) is considered part of the base pay for Postal Employees and some Department of Defense employees (except if they are overseas or in a foreign country).

- If the pay rate (including the "COLA") on the DOI or DDB is higher than that on the DOR, then the claimant is entitled to the highest pay rate (DOI or DDB).

U. S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

COST-OF-LIVING ADJUSTMENTS
UNDER 5 USC 8146a

EFFECTIVE DATE	RATE	PERIOD SINCE LAST CPI		EFFECTIVE DATE	RATE	PERIOD SINCE LAST CPI	
		DAYS*	MONTHS			DAYS*	MONTHS
10/1/66	12.5%	--	--	4/1/80	7.2%	183	6
1/1/68	3.7%	457	15				
12/1/68	4.0%	335	11				
9/1/69	4.4%	274	9				
6/1/70	4.4%	273	9				
3/1/71	4.0%	273	9				
5/1/72	3.9%	427	14				
6/1/73	4.8%	396	13				
1/1/74	5.2%	214	7				
7/1/74	5.3%	181	6				
11/1/74	6.3%	123	4				
6/1/75	4.1%	212	7				
1/1/76	4.4%	214	7				
11/1/76	4.2%	305	10				
7/1/77	4.9%	242	8				
5/1/78	5.3%	304	10				
11/1/78	4.9%	184	6				
5/1/79	5.5%	181	6				
10/1/79	5.6%	153	5				

* Calendar Days

Prior to 9/7/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.23 on a weekly basis ($.23, $.46, $.69, or $.92). After 9/7/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).

Prior to 11/1/74		Effective 11/1/74	
.08 - .34 = .23		.13 - .37 = .25	
.35 - .57 = .46		.38 - .62 = .50	
.58 - .80 = .69		.63 - .87 = .75	
.81 - .07 = .92		.88 - .12 = 1.00	

Form CA-841
April 1980

To determine TOTAL WEEKLY COMP. for TEMPORARY EMPLOYEES:

1) Look at CA-4, items #19, 22 or CA-7, items #22, 23 - if both are checked (✓) "No" (claimant didn't work 11 months of the year or would not have worked 11 months of the year), then claimant is considered a temporary employee.

   . Usually, employee works 5 days a week for an indefinite time.
   . Employee may typically be a 6-month temporary (e.g., with TVA) or an "89-day casual" (e.g., worked at the Post Office during a strike)

2) Determine the AVERAGE ANNUAL EARNINGS for the year preceding the injury to get at the weekly rate of pay.

   . If the temporary employee worked most of the year before the injury at the current federal agency, use the pay shown on the CA-4 (items #15,16) or CA-7 (items #19,20), as follows:

   - (Daily pay rate) x 150 (annual rate) ÷ 52 (weekly pay rate) x 2/3 or 3/4 (comp. rate)

     $52.08 x (150) = $7812 ÷ (52) = $150.23 x (3/4) = $200.31 (total weekly comp.)

   - (Hourly pay rate) x 8 = daily rate x (150) ÷ (52) x (2/3 or 3/4)

     ($6.51) x 8 = $52.08 x (150) = $7812 ÷ (52) = $150.23 x (3/4) = $200.31 (total weekly comp.)

NOTE: Claimant is entitled to 100% of the weekly pay rate if the weekly pay rate is LESS THAN the "minimum" in effect at time of injury.

   - Use "comp. rate" only if weekly pay rate is MORE THAN the "minimum".

   . If the temporary employee had other jobs (or was unemployed) in addition to the current job, then send a CA-1030 to the claimant and Agency - to determine what claimant would have earned if he/she had worked a set period.

- Request the actual annual earnings of a person in a similar class for the year previous to the injury. (Refer to FECA 8114 (d)(2))

- When the information is received, use the "150" formula or actual annual earnings claimant would have earned -- whichever is higher (Refer to FECA 8114 (d)(3))

- If temporary employee worked elsewhere during the previous year, then combine those earnings and temporary earnings to get average weekly pay (See below).

- Temporary employee is guaranteed at least:

  Daily rate at time of injury x (150) ÷ (52) x (2/3 or 3/4), or "minimum" if applicable.

3) Typical situations involving temporary employees: (See also Procedure Manual, 1-11-10 - 1-11-13)

- Similar jobs - claimant has a temporary job as a laborer for the U.S. Park Service, and was previously employed as a laborer working on construction of a subway system:

  a) Take combined earnings of both similar jobs to get a weekly rate of pay.
  b) Use the combined weekly rate of pay or the "150" formula, whichever is higher.

- Dissimilar jobs - claimant has a temporary job as a clerk, but previously worked as a laborer:

  a) Determine what claimant would have earned in a set period, equivalent to person in a similar class (e.g., a temporary clerk).
  b) Use either what he/she would have earned (actual annual earnings) or "150" formula, whichever is higher.

- No previous job - claimant has a temporary job as a messenger, but had no previous job during the year and is drawing unemployment comp.

  a) Determine what claimant would have earned, equivalent to a person in a similar class.

b) Use either what he/she would have earned or "150" formula, whichever is higher,

- Previous federal employment - claimant has a temporary job as a secretary and had a previous job as a clerk-typist in another federal agency in the year prior to the injury:

  a) Take the combined earnings of both jobs to get a weekly rate of pay.
  b) Use the combined weekly rate of pay or the "150" formula, whichever is higher.

See also Goldman, 23 ECAB 6

To determine TOTAL WEEKLY COMP. for PART-TIME EMPLOYEES:

1) Look at the:
   - CA-1 (items #24, 25, 26)
   - CA-2 (items #26, 27, 28)
   - CA-4 (item #17)
   - CA-7 (items #21, 35)

   . If claimant is not working regular, full-time, then he/she is considered part-time.

   . Part-time persons are not eligible for full FECA benefits since they have not demonstrated the capacity for regular, full-time work.

2) Determine the AVERAGE ANNUAL EARNINGS for the year preceding the injury to get at the weekly rate of pay.

   . If the claimant is a regular, part-time worker with fixed hours and/or fixed days (works the same number of hours per week), use the pay shown on the CA-1,2, 4 or 7, as follows:

   - (Hourly pay rate on date of injury) x (number hours regularly worked each week) = weekly pay rate x (2/3 or 3/4) = weekly comp. or "minimum" where applicable.

     ($6.51) x (20 hrs.) = ($130.20) x (3/4) = $97.65

   - (Hourly rate) x (8) = (daily rate) x (number of days worked) = weekly rate.

     ($6.51) x 8 = $52.08 x (3) = $156.24 x 3/4 = $117.18

   . If claimant is a regular, part-time worker who does NOT work the same number of hours per week (e.g., "flexible"):

   a) Send CA-1030 to get actual annual earnings for the one year prior to date of injury
   b) When the information (actual annual earnings) is received, determine average weekly earnings to get "average weekly pay"

      ($12,336) ÷ 52 = $237.23 (weekly pay rate) x (3/4) = 177.92 (weekly comp.)

   If the claimant is part-time, but not regular (e.g., irregular; "casual"; intermittent; "WAE" - when actually employed; working when needed, etc.), then daily rate fluctuates so you can't use it; you would:

a) Send CA-1030 to obtain average annual earnings for the year prior to injury and the number of days claimant was paid at each rate.

b) When information is received, use either formula below:

- Gross earnings (includes differentials, Sunday or holiday pay or other extra pay -- but not overtime) ÷ number of days = average daily rate of pay

  ($12,336) ÷ 156 days = $79.08 (average daily rate)

- (Hourly rate) x (8) = (daily rate) x (150) ÷ (52) = weekly rate.

  ($5.93) x 8 = ($47.45) x 150 = $7117.50 ÷ 52 = $136.88 (weekly pay rate)

  $136.88 x (3/4) = $102.66 (weekly comp.)

c) Use either the average weekly rate of pay or the "150" formula, whichever is higher.

- For additional information concerning part-time employees, refer to:

  - FECA 8114 (d)(3)
  - Procedure Manual 1-11-13
  - FPM Ch. 810, 3-2 a.(1)(b-d)

- RECURRENT PAY RATE

. Definition - Claimant is entitled to recurrent pay rate for a bona fide recurrence that occurs 6 months or more after claimant's first return to regular, full-time duty.

- References:
  . FECA 8101 (4) - "monthly pay"
  . Program Memoranda #59; #114 (entitlement to CPI's for recurrence) NOTE: Program Memo #164 does NOT apply to recurrent pay rate.
  . Appeals Board decisions:
    - Muro, Docket No. 65-239 issued 4/27/66, and Docket No. 67-205 issued 10/9/67.
    - Chinchillo, 18 ECAB 647
    - Rini, 20 ECAB 404
    - Neese, 21 ECAB 339
    - Gray, 22 ECAB 229
    - Spencer, 24 ECAB 251
    - Gilhooley

- Other terms defined:

  . "Recurrence" - claimant has returned to duty after injury/disease; stops work (because of a recurrence of the same injury/disease) 6 months or more after the original (or first) return to regular, full-time duty.

  . "Regular" duty - a bona fide job that is performed by others; not "make-work"; could be "light duty" as long as it meets the criteria of "regular" and full-time.

  . "Full-time" duty - at least 1 full-day (e.g., 8 hours); a half-day does not count.

To determine ENTITLEMENT to RECURRENT PAY RATE:

- Use Date of Recurrence (DOR) - use the base pay rate in effect as of the date of a bona fide recurrence (an injury/disease that occurs at least 6 months after claimant's first return to regular, full-time duty).

  . Claimant does not have to work 6 full months (e.g., straight time or 180 continuous days) between first

return to duty and recurrence (or latest recurrence).

Example:
- Jones is hurt Jan. 2 and stops work Jan.3
- Jones returns to full-time light duty Jan. 10
- Jones has recurrence April 1 and stops work
- Jones returns to duty April 4
- Jones has recurrence June 2 and stops work
- Jones returns to duty June 5
- Jones has recurrence July 17 and is still out.

Jones is entitled to recurrent pay rate as of July 17, which is the first time he suffers a recurrence that is more than 6 months after his first return to regular, full-time duty (Jan. 10).

In the above example, to determine the effective date of the pay rate for the recurrences on April 1 and June 2 (both of which occurred less than 6 months after Jones' first return to duty):

Pick the highest of these:

- DOI - use base pay rate as of date of injury
- DDB - use base pay rate as of date disability began (e.g., date employee stopped work)

. If there are additional recurrences after the 6 month requirement is met, then the claimant is entitled to the new recurrent pay rate --- once the 6-month eligibility is satisfied, claimant is entitled to all recurrent pay rates.

Example:
- Jones left work following recurrence July 17, at which time he is first entitled to recurrent pay rate
- Jones returns to duty Aug. 1
- Jones receives a pay raise Oct. 1
- Jones has recurrence Oct. 5

Jones is entitled to new recurrent pay rate since he has already met the 6-month eligibility requirement.

- Claimant is entitled to CPI's after one year from compensable DDB.

- Refer to Program Memo #114 for additional information on CPI's as they relate to recurrent pay rates.

. If claimant is getting a Schedule Award, and suffers a recurrence, then he/she is entitled to TTD at the recurrent pay rate. Further, if the DMI is not changed, the CE may interrupt the Schedule Award to pay TTD; after the period of TTD, the SA may begin--also at the recurrent pay rate.

Daily and Automatic Rolls

The daily and automatic rolls are the two ways by which claimants are most frequently paid. Below is a definition of each and on page(s) 124-125 a chart which shows when each should be used and how.

> Daily Payroll. System designed to make short-term disability compensation. The payroll is made up daily from a list of claimants who have minor disabilities. These claims are submitted at irregular intervals and processed for pay purposes upon receipt.
>
> Automatic Roll. List of compensation recipients and their respective compensation entitlements which is provided to the U.S. Treasury for automatic payment of compensation each 4 weeks (28 days) or each month (depending on payment schedule). The list is constantly updated on the basis of entitlement.
>
> To avoid overpayment and the possibility of keeping claimants on the roll beyond any applicable period, make at least a 3-month periodic check on claimant.

The type of roll a claimant is put on depends upon the type of compensation: LWOP, schedule award, LWEC, or disfigurement, and the extent of the disability. Also, the following applies:

- Daily Roll (DR): When it is determined that the claimant is no longer disabled for more than 3 months at the time the payment is being set up. For example: Claimant may have been disabled for 6 months; however, due to a time lag in processing the claim (e.g., additional information or medical opinions had to be requested and obtained), the claimant is no longer disabled at the time the payment is being set up.

- Automatic (A/R) or "Periodic" Roll: When it is known that the claimant will likely be disabled for more than 3 months from the date the payment is being set up. Prior to placing a person on the A/R there is a checklist (CA-674) which should be filled out.

- SUPPLEMENTAL Payment: When it is necessary to pay a claimant retroactively or for a period which falls between the end of a daily roll payment period and the time the automatic roll period begins, use the supplemental roll. The daily roll is not used to make future payments.

    - o Period between last DR payment and commencement of first AR period.
    - o Period between last date of AR period and date of RTW. For example, if claimant is on AR and returns to work on 1/22/77 and last AR period ends 1/15/77 - pay SR 1/16/77 - 1/21/77.
    - o To make an adjustment in pay/comp rate for claimant or AR.

  For example, daily roll payment should not be set up beyond the current date, if today's date is 1/15/77 and a payment is made on the daily roll for period 1/2/77 - 1/15/77 and payroll is given an effective A/R date of 1/29/77. It would be necessary to provide claimant with a supplemental payment for the period 1/16/77 - 1/28/77.

Type of Compensation	Extent of Disability	Place on Roll	Actions to Take
TTD	Disability is less than 3 months. Considered not severe.	Daily Roll	Set up payment on Form CA-800 based on information submitted by claimant on CA-8.
	Disability is 3 months or more, & is severe. Claimant continues to be disabled.	Most likely be placed on Automatic Roll	Fill out CA-25 as follows: o Box 2: Insert the words, "Prolonged Disability o Box 3: Insert the 3-digit enrollment code from Form CA-4 or CA-7 o Box 4: Insert the words "See Summary." o Box 5: Indicate work week. See CA-4 or CA-7 o Box 6: Insert amt. of weekly pay rate. o Box 7: Insert appropriate comp rate(TTD 3/4 or 2/3) & applicable CPI. O Box 8: Enter effective date claim will be put on Automatic Roll. Refer to "Automatic Payroll Schedule" for periods. o Box 9: Send Forms 1049 & 1653 to Claimant. o Box 10: Initial & date. o Box 11: Have a designated CE to certify by initialing & dating.

Type of Compensation	Extent of Disability	Place on Roll	Actions to Take
Schedule Award	Permanent Disability to a member & maximum improvement has been reached. Ending date of SA ends in the past (ends prior to date award is being set up)	Daily Roll	Set up payment on CA-800 See section on setting up payment for schedule award. Use Form CA-203 (Worksheet) in doing so. Dates used are based on Julian calendar. Denote date for Final payment.
	Permanent Disability to a member & maximum improvement has been reached. Ending date of SA goes into the future (beyond date award is set up)	Automatic Roll	Set up payment on CA-203 and notify claimant on Form CA-181 to explain specifics of award. Prior to expiration of award, send claimant Form 1051. Claimant may be eligible for LWEC.
LWEC	Permanent Partial Disability	Automatic Roll	Ask supervisor for guidance
Disfigurement	Permanent Disability	Supplemental Roll	Set up Form CA-25 Lump sum payment is made

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Disfigurement	Permanent Disability	Supplemental Roll	Set up Form CA-25 Lump sum payment is made

U.S DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	DISABILITY BENEFIT PAYMENT WORKSHEET	1. File No.: A1- 127954

2. Basis of action:

Prolonged Disability

3. Enrollment Code No.:	4. Last date of subscription deduction:	5. Employee's workweek:
102	See summary	S | M | T | W | T | F | S
6. Weekly pay rate:	7. Compensation rate:	8. Effective date:
$220.00 eff 12/2/74	TTD 3/4	5/16/75 + cont.
9. Form letter fill-in:	10. Examiner (date):	11. Certifier (date):
1653 & 1049	FM 5/20/75	MC 5/21/75

Comp. each wk.	Comp. each 4 wks.	Subscription deduction	Total comp. each 4 wks.

Compensation rate	Inclusive dates	No. days	Amount
Total			
Less paid			
Total Payment			

Payroll action: ☐ CA-45 ☐ CA-26

Date of roll:	By (date):	By (date):

GPO 878.449

Form CA-25
Rev. July 1974

Setting Up the First Payment of Compensation upon Receipt of CA-4 or CA-7

CA-800. The reverse of this form is used to set up compensation for TTD or schedule award. It is important that the CE write neatly, clearly and legibly within the spaces provided. If an error is made, do not write over it; instead, tape over it or white it out before making the correction. Use ink and do not skip lines. This document must be read by payroll.

CA-4 or CA-7. Check the below designated items of CA-4 or CA-7 against the items listed for CA-1 or CA-2 for agreement.

CA-4	CA-7	Check Against CA-1	CA-2
Item 4	Item 30	Item 32	Item 33
Item 5	Item 18	_____	Item 35
Item 17	_____	Item 31	_____

If date in item 4 or 30 differs from date in item 32 (CA-1) or item 33 (CA-2), use the last or most recent date of LWOP, and write OS for clarification. The same procedures are followed if a difference exists between data furnished in either item 5 or 18 of CA-4 or CA-7 and item 35 of CA-2.

If item 17 of CA-4 differs from item 31 of CA-1, use the work week shown in item 31 of the CA-1 because we know this is the work week at time the CA-1 was completed reporting the injury. The work week shown on the CA-4 may be the work week at the time the CA-4 is completed,which is usually several days after the CA-1 is completed.

If more than one payrate is given, or there is conflict in payrates - do not delay payment of compensation,but pay at the lower rate and call or write to the OS for clarification - then make retroactive adjustment.

To determine the number of DAYS in a Period of Award of compensation:

- Use Work Days ("WD") when:

  - o Claimant has a fixed schedule of work (e.g., M-F or T-Sat., or M, T, Th, F, Sat.), since you are counting the number of days claimant would have worked (and received pay) if he/she had been working.

  - o Usually, claimant is receiving TTD.

  - o Usually, claimant will be on Daily Roll.

  - o Use a regular calendar: start with the first date of the award and go through (include) the last date of the award ---- do not count normal days off.

    (Hint: If claimant normally works M-F count "work weeks" and multiply by "5" to get "days".)

- Use Calendar Days ("CD") when:

  - o Claimant does not have an established work-week (e.g., on-call or standby; irregular schedule; such as Peace Corps, seamen, VA personnel, fire fighters, police, etc.).

  - o Always use for Schedule Award

  - o May be used for LWEC or TTD.

  - o Use for a long period of award.

  - o Use to determine the ending date of an award.

  - o May use a regular calendar, but it is much easier to use the Julian Calendar ("Table of Julian Days").

- Refer to the Appeals Board decision (Wood, Docket No. 71-67, 22 ECAB 257) for further information on when to use "work" days or "calendar" days.

ADJUSTMENT ENTRY

Sometimes it is necessary to make an adjustment to a previous entry because all pay information (night differential, Sunday premium pay, etc.) is not available at the time the payment is set up. Waiting for the information before making payment would result in a delay in paying the claimant.

An adjustment entry can be made on the summary in several ways. One of the simplest ways is shown below:

First Line: Indicate the type of days (CD or WD) the letters "ADJ" to indicate adjustment; the total period, the number of days and amount of COP for that period.

Second Line: Write the phrase, "Less pol voucher (indicate voucher number) and amount".

Third Line: Indicate amount due, if any.

67. COP Earnings – WEC SA., etc.	Date		c. No. days lost	Rate of		f. Exam by	g. Cert by	h. Gross Compensation		HBS AND OPT. INS Periods	
(S)MTWTF(S)	a. from	b. to		d. pay	e. comp					i. from	j. to
WD ADJ 8	1/8/79	2/9/79	25	212.06	2/3			706	16		
	less previous pd. Voucher					BJ		xxx	xx		
WD 8		NET			✓	BJ		xxx	xx		

Type Payment Awarded	Steps to Take in Setting up Payment
TTD	Complete back of Form CA-800 1. Item 60 - fill in date & hour pay stopped. Get information from item 30 of CA-7. Write in same box: ·BOB if time denotes beginning of business ·COB if time denotes close of business, or the words "after ____hours." 2. Item 61 - Write in "NWD" (no waiting days) if claimant's disability is over 14 days. If less, write in the dates that are to be used as waiting days. You should count calendar days. 3. Items 62, 63, 64 - Leave blank. 4. Item 65 - Write in date of birth, e.g. "DOB 3/14/38" if client has optional insurance. 5. Item 66 - Write in reason for effective date of pay rate. (See"Types of Pay Rates" page ·DOI, if pay rate is effective as of Date of Injury; or ·DDB, if pay rate is effective as of Date Disability Began; or ·DOR, if pay rate is effective as of Date of Recurrence. 6. Item 66a - Fill in date which corresponds to reason placed in block 66. 7. Item 66b - Fill in weekly pay rate. See Section "Determining Compensation" on how to compute. 8. Item 66c - Fill in weekly night differential if applicable. 9. Items 66d, 66e - Fill in if claimant received some other premium pay, such as holiday, Sunday, etc. Figure must represent a weekly rate. 10. Item 66f - Fill in total weekly rate; sum of 66b, 66c, 66d, and 66e.

Type Payment Awarded	Steps to Take in Setting up Payment
TTD	11. Items 66g & 66h - Leave blank 12. Item 66i - Write in claimant's Health Benefit Code - a 3-digit number. Form CA-7, item 32 contains this code; if not obtain from Agency. If claimant has no Health Benefit insurance, write N/A in block. 13. Item 66j - Fill in date Health Benefit deductions began. See Form CA-7, item 32 for date. If date is missing and Health Benefits block is checked "Yes", use date of first full pay period after claimant goes into LWOP. 14. Items 66k & 66l - Leave blank. 15. Item 66m - Fill in date Optional Insurance Benefits deductions became effective if applicable. Date will be same as in 66j. If "optional insurance"block is checked "Yes" and date is missing, use date of first full pay period after claimant goes into LWOP. If none, write N/A. 16. Item 67 - First line:fill in claimant's work week from data furnished in item 21 of CA-7. Examples are: M-F, "off S&M", etc. Indicate whether days worked are work days (WD) or intermittent calendar days (CD). If a CA-8 (claim for compensation when loss of pay continues beyond time claimed on CA-7) is to be released insert an "8" in this block. If final payment, put F, RTW (returned to work) and date or "FFD" (fit for duty). An entry may look like one of the following: M-F WD 8 RTW 5/7/77 WD F FFD 5/7/77 WD F 17. Item 67a - Indicate first date compensation is to be paid. See item 6, CA-7. 18. Item 67b - Indicate ending date of compensation. This date is determined by the number of days lost.

Type Payment Awarded	Steps to Take in Setting up Payment
TTD	19. Item 67c - Indicate the number of days lost. Count on a calendar for each work day lost. Time claimed must be supported by medical evidence. 20. Item 67d - Fill in Total Weekly Pay Rate. This has already been computed for Item 66. 21. Item 67e - Fill compensation rate. "2/3" if claimant has no dependents; "3/4" if claimant has one or more dependents. 22. Item 67f - Place your initials in this block and give to a designated CE for certification. Item 67 - Second line, write in the word "Recredit", indicate when claimant returned to duty, e.g., "RTD 4/20/76", and payment is final (F). An entry would look like this: "Recredit RTD 4/20/76 F." Across from entry indicate name of Agency payment is made to. In item "f", place your initials. In item "h" enter total comp. paid. NOTE: Payroll completes items #67 g-r. Payroll sends claimant's Agency Form Letter CA-1003 ("x" box 7) at the time claimant's check is forwarded.

Type of Payment	Item	Steps to Take in Setting Up Payments
Schedule Award		Acquire a "Schedule Award Worksheet", Form CA-203 from office supply, and complete as follows.
	1.	Write in case file number. Same number as contained on outside of file.
	2.	Write in date of injury. Take from item 4 if CA-4, item 9 if CA-1.
	3.	Fill in weekly wage & effective date. See section on how to determine compensation for computation procedures.
	4.	Check block marked "Yes" if claimant has dependents, "No" if he/she has none.
	5.	Indicate the percentage of disability and the affected member.
	6.	Write in number of weeks of compensation. Use Form CA-699 (Table of Schedule Award) to determine the number of weeks and days to put in this item. The schedule is read as follows o Look down left side for disabled member o Look across top for percentage of disability given you in Medical Director's report. You may have to add 2 figures together i.e., 18% of the arm figures for 15% + 3%. o The number of days claimant will get compensation for is indicated at point where the percentage & disabled member lines intersect. These are calendar days.
	7.	Check appropriate compensation rate block, "3/4", if claimant has dependents, "2/3" if he/she does not. CA-4, see item 10, CA-7, see item 13. Include in this block also, the weekly amount of compensation. See section on "Determining Compensation" for method of compensation.

Type of Payment	Item	Steps to Take in Setting Up Payments
Schedule Award		
	8	Fill in this item only if "Period of Award" ends in past, otherwise, leave blank. If "Period of Award" does end in the past, obtain a CA-800 and fill in as follows: o Leave items 60 & 61 blank o Fill in items 66 through 66h. See steps for LWOP. o Leave items 66i through 66m blank. o Fill in items 67 through 67f. Days worked are always calendar days (CD)- and award is always final (F). In item 67, make the notation "SA, CD, F" which reads schedule award, calendar days, and final.
	9	Use Julian Calendar.
	10	Send claimant a copy of the "Award of Compensation" form, CA-181; a copy to O.S., and place a copy in file. Maintain the original in file. Note in this block, "CA-181 to claimant, cc to file, cc to O.S." Include other information, e.g., date of CPI or amount of deduction (if applicable).
	11	Write your initials in this block.
	12	Date form and give to certifier (a designated CE in your office) for certification. • If the expiration of the period of award is more than 3 months from the date the award is set up, award is considered "going into the future". Payroll will prepare a plate and place claimant on the automatic roll (unless claimant is already on the A/R). It will be necessary for CE to notify claimant 3 months prior to expiration of award by sending claimant a Form CA-1051. Three weeks before claim expires, advise Payroll Division that plate should be destroyed effective a certain date. See Section on "Termination of Compensation". • If the expiration of the period of award is less than 3 months from the date the award is set up, award is considered "ending in the past" -- claimant goes on Daily Roll.

CA-3: REPORT OF TERMINATION OF DISABILITY AND/OR PAYMENT

General Principles

- The CA-3 is submitted when the claimant (who has been receiving either COP or compensation) returns to work, or when the 45 days of COP has expired.
- When the CA-3 is returned by the Agency for a claimant who has been receiving COP, the CA-3 shows wither the period that COP is being paid (and the claimant has returned to work) or that the COP has expired, as shown below.

Look at CA-3	Significance
#9 - to see when COP expired #10 - to see when claimant returned to work #18 - to note period that COP is being paid	o If COP has expired and claimant has returned to duty: close-out case (initial, date) on summary sheet o If COP has expired and claimant has NOT returned to duty: claimant should have attached a CA-4 or CA-7 to claim compensation o If COP has NOT expired and claimant has returned to duty: close-out case on summary sheet
#9, 13 - shows inclusive dates of sick or annual leave	o Claimant may be entitled to re-purchase ("Buy-back") leave
#12, 20, 21 - to see if pay rate (in claimant's job) changes	o If pay rate the same or INCREASES: not significant o If pay rate DECREASES: claimant may be entitled to comp. for a loss-of-eage earning capacity (LWEC)

#14 - to see if claimant's job duties changed after return to work (especially look for a "downgrade")	o If duties CHANGED: not significant unless pay rate DECREASED o If duties did NOT change: no significance

NOTE: When CA-3 comes in, make appropriate notation on summary (item #67)---see next page.

- When the CA-3 is returned from the Agency for a claimant who is receiving COMPENSATION, it shows only that the claimant has returned to work, as shown below.

Look at CA-3	Significance
#10 - to see when claimant returned to duty #17 - to see if there is a notation concerning when last payment was made #67 - on summary sheet - to see when last payment is (or was) to be made	o If claimant has been paid UP TO the date claimant has (or will have) returned to duty: no significance. (Pay claimant up to date returned to duty.) o If comp. is being paid BEYOND the date claimant returned to duty: there will be an over-payment
#12, 20, 21 - to see if pay rate changes	o If pay rate the SAME or INCREASES: not significant o If pay rate DECREASES (loss of pay): claimant may be entitled to compensation for LWEC
#14 - to see if job duties changed after return to duty (especially check for "downgrade")	o If job duties CHANGED: not significant unless pay rate DECREASED o If duties did NOT change (and pay rate is the SAME or INCREASES): terminate compensation for disability as of the date claimant returned to duty. (See section on "terminating compensation")

NOTE: When CA-3 is returned for claimant receiving COP, and 3P is involved, make the following entries on the Summary Sheet:

#67. CD COP (indicates "Calendar Day, COP)
67a. Beginning date of COP (from CA-3, item 13 or 18)
67b. Ending date of COP (from CA-3, item 13 or 18)
67c. Number of DAYS lost (compute, from CA-3, item 13 or 18)
67d COP
67e. 100%
67f. Initial
67h. Gross COP, leave, etc. paid (from CA-3, item 19)
67r. DO NOT PAY (for Payroll)

TERMINATING COMPENSATION
(TTD - Daily or Automatic Roll; LWEC)

If type of Comp. is:	Check	Terminating Procedures
TTD (Daily Roll)	CA-3, #10. to see if claimant returned to duty. #17. to see if there is a notation concerning when last payment was made #67. Summary Sheet to find out when 1st payment was made. RTD 4/1/77 WD F	If compensation has been paid beyond date claimant returned to duty, send Form Letter CA-2202 to claimant, carbon copy to O.S., and put a copy in the file. Request claimant to refund overpayment. Set up O/P, have it certified. This will be a 3 line entry on CA-800. Example 3/21/77 - 3/31/77 9 days Less prev. paid same period. Compute O/P If compensation has not been overpaid, pay claimant up-to-date and close file. If already paid up-to-date, close file. Advise claimant.
TTD (Automatic Roll)	Check "Automatic Pay Period Schedule" for next scheduled periods U.S. Treasury will pay comp. This schedule is kept in the office. CA-1032 - sent once a year to claimant to determine wages earned and any change in claimant's wages or dependent status.	Terminating compensation before plate ends: o Send Form CA-25 to payroll. In box 2, write: "claimant on automatic roll (AR) & has returned to duty (RTD) on (date); destroy plate effective (date); pay on supplemental roll (SR) from (date) to (date); close case as paid".

If claimant returns to duty before plate ends, over-payment to claimant has occurred, and there's no time to destroy plate (cut-off date for notifying U.S. Treasury is past), do the following:

- o Destroy plate as of beginning of next automatic pay period. Use CA-25.
- o Furnish payroll with dates in which over-payment was made.
- o Request payroll to compute the amount owed.
- o Determine whether O/P can be waived.
- o Send CA-2202 to claimant requesting over-payment be refunded to FECA, if appropriate.
- o If over-payment is not sent in, request again. Then ask OS to take from payroll check.
- o Complete CA-25 as above.

If claimant returns to duty before plate ends, and there's no time to destroy plate, and Treasury has not sent claimant check:

- o Notify U.S. Treasury to VOID check
- o Pay claimant on supplemental roll (lump sum) for period owed, and
- o Destroy plate effective at beginning of next automatic pay period.

Terminating A Schedule Award and Initiating Other Actions

There will be occasions when it is necessary to pay other benefits subsequent to the termination of a schedule award. When this action is required, the claimant is disabled to the extent the employer cannot use him/her to perform his regular work and from earning comparable wages. This results in the claimant receiving less pay than he/she did before the injury. If the injury is severe enough, he/she may not be able to work at all, thus having a total wage loss. Initiating LWEC at the time a schedule award is terminated permits claimant to be compensated for his/her loss of wage earning capacity.

Procedures to follow for initiating LWEC are:

- o Terminate the schedule award as outlined in section Terminating Compensation, pages 138-140 .
- o Send claimant Form CA-1051 to inform him/her that the Schedule Award is ending and, he/she may apply for additional benefits by providing additional information by completing it and returning it to FECA. This form also informs claimant of his right to apply for LWEC.
- o If claimant has returned to work and no wage loss has occurred (see Form CA-3), close case.
- o Close case if Form CA-1051 is not returned.

If Form CA-1051 is returned, claimant is asking for additional benefits. Write to appropriate Agency and request the current pay for claimant's old job. You'll need this to compute compensation for LWEC. Obtain current medical evidence from claimant's doctor by sending claimant Form CA-1311 and doctor a CA-1316. In Box #4 add: "Please submit a narrative report of your finding and complete the reverse of this form." When returned, check with your supervisor for procedures to follow.

Vocational Rehabilitation

Another option for the CE to consider when terminating a schedule award is possible vocational rehabilitation for the claimant. If the employee has not returned to work, follow the procedures in the section on Vocational Rehabilitation, pages 154-156 to determine if claimant is a candidate for vocational rehabilitation. Do not do this unless person is young and cannot earn comparable wages, or if requested by claimant. If accepted by Rehab., he/she has to be placed on AR for TTD until Rehab. program is completed.

o Increase in Schedule Award

In order to grant a claimant an increase in compensation, claimant's medical history must be re-evaluated by the DMD. Refer claimant for current medical record (use Form CA-1311 to claimant, CA-1303 to DR). Medical data should be less than 6 months old. When data is received, prepare a CA-99 and submit to DMD for current medical opinion.

o Rate Person for Work

When the evidence shows claimant cannot perform previous work, but can do something else, the CE has the task of rating claimant for another job. The following criteria may be used in making such a determination:

- the medical report is the key document and should not be more than 6 months old. It must indicate claimant can do some type of work.
- check claimant's age; if it is 60 or more, bear in mind the difficulty in finding a job at that age.
- check claimant's education; if it is limited, combination of this and being over 60 makes claimant's job possibilities even more difficult, and,
- check source documents for any physical disabilities claimant has other than those FECA is paying for.

After doing the above, if you decide not to rate employee for some kind of work, consult your supervisor for further guidance. If you do rate claimant, take the following actions:

- Send claimant to State Employment Service to determine what employement is available within claimant's commuting area.
- Four forms are sent to claimant:

  CA-1654 - advises claimant to register with SES,

  CA-1654a - requests information regarding evaluation of disability to perform work

  CA-1654b - Provides information useful to claimant in seeking employment

  CA-2102 - Advises claimant that he/she will be interviewed by SES.

. Send SES the following three forms:

CA-2102a - Provide pertinent information which will enable SES to make a job classification determination

CA-815 - Provide data on claimant's medical restrictions, and

CA-50 - A worksheet for SES

"BUY-BACK" (REPURCHASE OR RECREDIT) LEAVE

GENERAL PRINCIPLES

- o Definition - FECA is essentially paying back the employing Agency Payroll Department for leave taken by a claimant for a job-related injury rather than for what FECA would have paid the claimant in compensation.

- o "Buy-back" applies when:

  - The claimant was on leave due to a job-related injury, and
  - the claimant used sick or annual leave, and
  - the claimant now wants the used leave back on his/her time card.

    - Claimant is out with an injury for 3 months.

    - Claimant has accumulated a considerable amount of sick leave prior to the injury.

    - Claimant uses 3 months of sick leave before he returned to duty, and is left with little leave remaining.

    - Claimant decides, upon return to duty, that he might need that sick leave for future use. So he desires to use only 2 months of sick leave for his injury, and to "buy-back" his other month of sick leave from the Agency, thus taking the other month as leave without pay (LWOP).

    - Claimant then applies to the Agency to buy-back (or repurchase) 1 month of sick leave.

    - Agency approves claimant's request to buy-back the leave used for that month, and puts him on LWOP (paid by OWCP) status for that month.

    - CE approves LWOP for claimant for one month.

- o The claimant claimed compensation for LWOP but used sick or annual leave (in which case, FECA cannot pay compensation - since person was, in effect, on leave with pay.)

  - Check the CA-4 (#18) or CA-7 (#7, #25) whidh indicates:

    - o if sick or annual leave was used
    - o period for which compensation is claimed

- Ascertain that medical evidence supports disability for the period for which compensation is claimed. (If medical evidence is not available, you must obtain it.)

Some CE's inform the claimant of the right to buy-back leave when block 13 of the CA-1 or blocks 7 and 25 of the CA-7 indicate sick or annual leave was used. This should not be necessary, providing the responsible Agency Compensation Specialist (CS) has informed the claimant of buy-back procedures. However, in instances where it appears the claimant has not been advised of his right to buy-back leave, sending a CA-1207 could be in order.

If the CS is on-the-ball, so to speak, the claimant will have been made aware of the right to buy-back leave. Basically, the CS should have advised the claimant,

- o that in order to be eligible to buy-back leave, the claim must have been approved (adjudicated) by OWCP;

- o that there is no time limitation for buying back leave as long as the claim was filed within the 3-year time period. A person who claims to be injured on-the-job in November 1972, but who had not filed a claim with OWCP, would not be eligible to buy-back leave today.

- o how the buy-back system works;

  - employee uses sick or annual leave while off from work due to a job-related injury. Employee's Agency credits the employee's leave record accordingly.

  - employee files for compensation and the claim is approved.

  - employee informs own Agency in writing of the desire to buy-back leave and at the same time request the Agency advise claimant of amount of leave being credited and the amount of money he/she owes as a result of the leave restoration.

  - if approved, payroll advises employee in writing. Employee then forwards a copy to OWCP. (Note the CE need not send claimant a CA-1207 when this occurs.)

- CE then takes action to insure OWCP reimburses the Agency based on compensation entitlement with the employee receiving or paying the difference.

o that, if less than 14 days of leave are used, the first 3 days are not covered for compensation and no reimbursement is given for those days, and

o that, an adjusted W-2 Form should be requested from payroll at the end of the year for tax purposes.

Actions to Take when person wants to, or has to, buy-back leave:

- Option 1: Send CA-1207 to claimant.
It indicates:

o Period for which compensation is claimed.

o Gross amount of compensation to be paid to the Agency Payroll Department for the period claimed. (You must calculate the amount of compensation.)

o Claimant is to fill in items #1-4 on the reverse side and forward the form to an accountable officer of his/her employing agency who will complete items #5-8 and return the form to FECA. The CA-1207 then serves as an application to buy-back leave.

- Option 2: Send CA-1043 to claimant.
It indicates:

o (Box 2) Claimant's absence from work is covered by leave.

o (Box 3, CE writes in "Please note buy-back instructions on the attached procedural letter") Claimant should follow instructions on procedural letter in returning CA-1043 to FECA in order to "buy-back" leave.

o No computations of compensation are involved if you use this form.

- Make a 2-line entry on line #67 on the CA-800 indicating:

  - o Payment (amount)
  - o "Pay to Agency"

- Fill in CA-800 (reverse side) as follows:

  - o Bracket out period claimant used leave to indicate that leave is being converted

  - o Item #60: date/hour pay stopped (first day of leave "buy-back"; indicate whether it's "BOB" beginning of business day) or "COB" (close of business day) or portion of a day.

  - o Item #61: waiting days, if any (fill in dates) or no waiting days ("NWD" or "N/A")

  - o Item #66: date pay rate is effective; may be:

    DOI - Date of Injury
    DDB - Date Disability Began
    DOR - Date of Recurrence

  - o Item #66A: actual date of pay rate being used

  - o Item #66B: weekly base pay rate

  - o Item #66C: night differential, if any

  - o Item #66D & E: Sunday, holiday or other differential, if any

  - o Item #66F: total weekly pay rate

  - o Item #66G-M: leave blank

  - o Item #67: claimant's work week; indicate (in first box) whether work days ("WD") or (calendar) days ("CD"); indicate (in lower box) whether "8" (if CA-8 is to be released) or "F" (final payment). Usually, the buy-back leave is completed by an "F", followed by "RTW" (returned to work--indicate also the date).

  - o Item #67A: first date comp. is to be paid

  - o Item #67B: end date for comp.

Actions to Take when claimant returns either the CA-1207 or responds to the CA-1043, indicating desire to repurchase leave:

1) Set up payment on CA-800 ("Summary Sheet") as for DAILY ROLL for LWOP, except:

   - there is no health benefit ("HB" - item #66 I) or optional insurance ("OI" - item #66 M).

   - write in "F" (Final Payment) and "Recredit" in item #67.

   o Item #67C: number of days lost

   o Item #67D: total weekly pay rate (from #66F)

   o Item #67E: comp. rate (2/3 or 3/4)

   o Item #67F: initial

2) Send CA-1208 to claimant advising claimant that payment is on its way!

DUAL BENEFITS

Refer to:
- FECA 8116
- FPM, Chap. 810, subchapter 3-8
- Program Memoranda 69, 166, 180
- Appeals Board decisions:
  - Stuczynski, 12 ECAB 159
  - Fite, 21 ECAB 236
  - Counts, 23 ECAB 152
  - Akers, 24 ECAB 316

In general, the FECA prohibits the payment of dual benefits for disability or for death.

A. VA

- GENERAL PRINCIPLES:

  . The concurrent payment of FECA comp. and VA pensions for non-service connected disability or death is not prohibited.

  . VA benefits (e.g., VA comp., indemnity comp., dependency or educational assistance) can be received concurrently with FECA compensation EXCEPT when:

  - The VA increases claimant's benefits.
  - A student is entitled to educational benefits.

  In these situations, an irrevocable election of benefits must be made.

- MILITARY RETIREMENT

  . The law provides for the concurrent payment of military retirement and comp. (except when claimant is an officer under 5 USC 5532 (b). The examiner should pay compensation since it is claimant's right to receive compensation. However, he/she should write to the respective service Finance Officer alerting him/her that OWCP is paying compensation. Indicate the inclusive dates, or if FECA is continuing the payment. In the event of continuation of payment, advise the military Finance Officer when compensation under FECA ceases so claimant can once again receive military retirement benefits.

- The law also permits the payment of compensation concurrently with VA benefits EXCEPT when:

  1) VA and OWCP are paying for the same injury or death - and VA increases its benefits.

     Example:

     - During World War II, claimant sustained a bullet wound in the left leg, for which VA is paying for 10% permanent impairment to the left leg.
     - Claimant was discharged, entered civilian government employment, and subsequently fractured his left leg.
     - When claimant reaches MMI and has RTD, the medical evidence shows he has 25% permanent impairment to the left leg.
     - Taking into account any pre-existing impairment to the same leg, claimant is entitled to receive a Schedule Award for 25% impairment to the left leg. Thus, he is now receiving a total of 35% benefits. So far, this is not a dual benefit situations since, for pay purposes, no increase has taken place.
     - However, claimant goes to the VA to advise them of an increase in impairment to the left leg. After examining the claimant, the VA increases his benefits from 10% to 25%. Claimant would now be receiving a total of 50% benefits, if allowed.
     - The 15% VA increase in benefits creates a dual benefit situation: the claimant must make an election, choosing either the total of 35% benefits (25% from FEC, plus the basic VA benefit of 10%) or the total of 25% from VA (the initial 10%, plus the increase of 15%).
       . This election is irrevocable -- claimant cannot change back to VA once the election for FECA is made. However, a new election can be made if claimant is rated for LWEC. (See Program Mem. 180.)
       . In this example, the "left leg" includes the left foot and left toe; if VA increases benefits for any part of the left leg, then an election is required.
       . However, if VA is paying 10% for the left leg, and claimant sustains a job-related injury to any other member of the body (e.g., right leg), then claimant is entitled to benefits/comp. from both the VA and OWCP.

2) Educational benefits involved in a death case -- the law prohibits the concurrent payment of OWCP Educational Benefits and the VA-sponsored War Orphans Educational Benefits. An irrevocable election must be made.

. Burial allowance: when there has been military service, any burial allowance paid by VA is deducted from the FECA burial allowance of $800.

ACTIONS to TAKE if VA benefits are involved:

. Forms: Use CA-1018 to claimant and CA-1019 to VA Office. Send the forms only if the file shows claimant is receiving VA benefits and you don't know why (see CA-1, 2, 4 and 7).

. When there is verification that claimant is receiving VA benefits, send a narrative to claimant requesting that an election be made.

- If the claimant elects FECA benefits (they usually do), the CE has less work (than if CSC is involved) since the VA does not ask for reimbursement of annuities it has already paid ... and the election is irrevocable.

B. CSC

- GENERAL PRINCIPLES:

. FECA compensation for TTD or LWEC and benefits under the CSC Retirement Act may not be paid concurrently for the same period of time. An election of benefits is required.

- The election is revocable--claimant can change his/her mind once FECA benefits are elected, and return to CSC benefits.

- When the CSC indicates that its annuities have stopped, then it also informs the CE that OWCP must reimburse the CSC for annuities paid during the period of entitlement to FECA compensation.

As a result of the 1960 Amendments (see S/A Chart page 83a), claimant is entitled to dual benefits for:

- Medical benefits from FEC concurrent with CSC retirement annuity.
- Schedule Award for any injury occurring on or after 9/13/57, concurrent with CSC benefits.

ACTIONS to TAKE if CSC is involved:

- If claimants are at least 55 years old, chances are they are on CSC retirement - even if they don't so indicate on the claim.
- Determine whether an election must be made:

Check Form	Type of Comp.	Action
CA-4, item 4 CA-7, item 4 and 6	TTD & LWEC	. Dual Benefits are NOT permitted..claimant must make an election.
CA-4, item 8 CA-7, item 12	Civil Service Retirement	. If indicated, send claimant Form CA-1102 (disability)or CA-1103 (death) & 2 blank CA-1105's. When returned, send one completed CA-1105 to CSC with one CA-1104. Check appropriate boxes on CA-1104. . If not indicated, you may send a Form Letter CA-1101. If returned checked "Yes" - follow steps above. Do this if you believe a claim might have been filed with CSC. Otherwise it is a waste of time and energy.

C. SOCIAL SECURITY

- SSA benefits may be received concurrently with FECA benefits. The SSA does have some restraints against upper income level in their statute, however.

Vocational Rehabilitation (Voc. Rehab.)

General

- The FECA provides for the cost of OWCP-directed vocational rehabilitation necessary to counteract the disabling compensable effects of any permanent illness or injury causally related to Federal employment. The cost of rehabilitation is paid from the Employees' Compensation Fund, and rehabilitation is usually administered through State vocational rehabilitation agencies with approval of OWCP. In addition to the cost of rehabilitation, an employee may qualify for a monthly maintenance allowance of up to $200. This is based on a need basis covering such items as transportation, lunch or any items incidental to the situation. Vocational rehabilitation benefits are supplemental, and recipients are also entitled to collect total disability payments during the period of their rehabilitation.

- A claimant's initial involvement with the vocational rehabilitation process consists of answering the rehabilitation advisor's requests for information. The advisor uses this information, combined with information obtained during an interview with the claimant, to determine the type of program that would best suit the claimant. When a claimant completes his or her rehabilitation program, he or she is expected to actively seek employment. The Rehab Officer advises the CE by memo of claimant's completion of training. Since the claimant has been retrained, his or her wage-earning capacity for compensation purposes would be based on the newly acquired skill, rated at the entry level. In many cases, even if a claimant is unable to find work, his or her new wage-earning capacity would be high enough so that he or she would no longer be eligible for FECA compensation awarded on the basis of loss of wage-earning capacity (LWEC).

- The CE should refer claimants to Voc. Rehab. to determine whether the claimant can perform some kind of work in spite of a disability, and/or to train or retrain a claimant for some kind of work in order to get the person off compensation for LWEC. However, it is the Rehab Officer responsibility to acquire a job for claimant at the employing agency.

Criteria for Referring Cases to Voc. Rehab.

- To consider cases for Voc. Rehab., four criteria must be apparent:

- Claimant has a permanent disability,

- Claimant can no longer perform regular duties

- Claimant has been disabled for 90 days or more,

- Claimant is on the AR.

o Action to Take to Refer Case to Voc. Rehab.:

- Complete Form CA-55 when claimant is placed on AR and send to Rehabilitation Specialist.

Voc. Rehab. Decisions

o Voc. Rehab. may either accept person into a Voc. Rehab. program or turn the person down.

o If Voc. Rehab. agrees that claimant is a "good" candidate:

- Voc. Rehab. will KEEP the case.

- The CE should then:

1) Find out what the claimant will be trained to do.

2) Put a 3-month "call-up" on the case to get a progress report.

o If Voc. Rehab. does NOT consider claimant a "good" candidate:

- Voc. Rehab. will refer the case back to the CE

- The CE should then try to "rate" the claimant for some kind of work, in consideration of person's ability to compete in the labor market.

o If claimant has completed rehabilitation training and a 60-day grace period has been allowed for claimant to look for a job.

. Acquire the going salary of job claimant has been trained to do

. Complete Form CA-816

. Prepare a CA-25 for payroll plate action to inform payroll of the amount of reduction in compensation.

. Send claimant a CA-1048 and CA-1048a to advise of reduction in compensation and appeal rights.

USE OF THE JULIAN CALENDAR

The Julian Calendar (also known as the "Table of Julian Days") is used to determine the number of weeks or days within a known period of compensation, or to determine the terminating date of compensation when the number of weeks or days is known.

Usually, the CE is given the beginning date of compensation and the number of days for which comp. is to be paid, and then must determine the ending date of compensation.

Claims examiners frequently complain that the Julian Calendar is too complex to use. Consequently, many CE's end up counting the days in a "Period of Award" on a standard calendar. However, when the Period of Award is a lengthy one, the process of counting days in this manner is both tedious and time-consuming. In addition, if the Period of Award goes far into the future, standard calendars may not be readily available. CE's who do use the Julian Calendar suggest that it provides a short-cut worth learning. A calculator is still necessary to decrease the potential for mathematical errors.

TO DETERMINE THE NUMBER OF WEEKS OR DAYS WITHIN A KNOWN PERIOD.

Example: The DMD tells you the period of disability (period of time for which compensation is payable) is from August 1, 1952 to May 18, 1953 (but does not include 5/18/53) Determine the number of DAYS in the Period of Award. Then, convert the days into WEEKS/DAYS.

1) Find the beginning month at the TOP of the page: "Aug. 0"
2) Find the beginning year at the LEFT of the page: 1952
3) Move down the column for the month ("Aug. 0") to the line which corresponds to the year (1952) and record the number at the intersecting point: 4225
4) To the "intersecting number" (4225), add the day (01) of the beginning MONTH: 4225 + 1 = 4226
5) Find the terminating month at the TOP of the page: "May 0"
6) Find the terminating year at the LEFT of the page: 1953
7) Move down the column for the month ("May 0") to the line which corresponds to the year (1953) and record the number at the intersecting point: 4498

8) To the "intersecting number" (4498), add the day ("18") of the terminating month: 4498 + 18 = 4516

9) Subtract the beginning number (4226) from the terminating number (4516) to get the DAYS: 4516 - 4226 = 290 DAYS

10) Convert the DAYS (290) into WEEKS by dividing by "7": 290 ÷ 7 = 41 WEEKS, 3 DAYS

TO DETERMINE THE TERMINATING DATE WHEN THE BEGINNING DATE AND NUMBER OF DAYS ARE KNOWN.

An easy method for finding the ending date of a period is as follows:

JULIAN CALENDAR FORMULA

Code for Month and Year: _____

\+ Days of month: _____

= Base figure: _____

\+ Compensation Days: _____

TOTAL : _____

\- Next lower figure (Which give the month and year) _____

= The days of the month: _____

NOTE: If no fraction, subtract 1 day for inclusive dates. If there is fraction, show FOD on the CA-203.

(Courtesy of the San Francisco District Office)

TABLE OF JULIAN DAYS

Year	(1) Jan. 0	(2) Feb. 0	(3) Mar. 0	(4) Apr. 0	(5) May 0	(6) June 0	(7) July 0	(8) Aug. 0	(9) Sept. 0	(10) Oct. 0	(11) Nov. 0	(12) Dec. 0
1951	3647	3678	3706	3737	3767	3798	3828	3859	3890	3920	3951	3981
1952	4012	4043	4072	4103	4133	4164	4194	4225	4256	4286	4317	4347
1953	4378	4409	4437	4468	4498	4529	4559	4590	4621	4651	4682	4712
1954	4743	4774	4802	4855	4863	4894	4924	4955	4986	5016	5047	5077
1955	5108	5139	5167	5198	5228	5259	5289	5320	5351	5381	5412	5442
1956	5473	5504	5533	5564	5594	5625	5655	5686	5717	5747	5778	5808
1957	5839	5870	5898	5929	5959	5990	6020	6051	6082	6112	6143	6173
1958	6204	6235	6263	6294	6324	6355	6385	6416	6447	6477	6508	6538
1959	6569	6600	6628	6659	6689	6720	6750	6781	6812	6842	6873	6903
1960	6934	6965	6994	7025	7055	7086	7116	7147	7178	7208	7239	7269
1961	7300	7331	7359	7390	7420	7451	7481	7512	7543	7573	7604	7634
1962	7665	7696	7724	7755	7785	7816	7846	7877	7908	7938	7969	7999
1963	8030	8061	8089	8120	8150	8181	8211	8242	8273	8303	8334	8364
1964	8395	8426	8455	8486	8516	8547	8577	8608	8639	8669	8700	8730
1965	8761	8792	8820	8851	8881	8912	8942	8973	9004	9034	9065	9095
1966	9126	9157	9185	9216	9246	9277	9307	9338	9369	9399	9430	9460
1967	9491	9522	9550	9581	9611	9642	9672	9703	9734	9764	9795	9825
1968	9856	9887	9916	9947	9977	0008	0038	0069	0100	0130	0161	0191
1969	0222	0253	0281	0312	0342	0375	0403	0434	0465	0495	0526	0556
1970	0587	0618	0646	0677	0707	0738	0768	0799	0830	0860	0891	0921
1971	0952	0983	1011	1042	1072	1103	1133	1164	1195	1225	1256	1286
1972	1317	1348	1377	1408	1438	1469	1499	1550	1561	1591	1622	1652
1973	1683	1714	1742	1773	1805	1834	1864	1895	1926	1956	1987	2017
1974	2048	2079	2107	2138	2168	2199	2229	2260	2291	2321	2352	2382
1975	2413	2444	2472	2503	2533	2564	2594	2625	2656	2686	2717	2747
1976	2778	2809	2838	2869	2899	2930	2960	2991	3022	3052	3083	3113
1977	3144	3175	3203	3234	3264	3295	3325	3356	3387	3417	3448	3478
1978	3509	3540	3568	3599	3629	3660	3690	3721	3752	3782	3813	3843
1979	3874	3905	3933	3964	3994	4025	4055	4086	4117	4147	4178	4208
1980	4239	4270	4299	4330	4360	4391	4421	4452	4483	4513	4544	4574
1981	4605	4636	4664	4695	4725	4756	4786	4817	4848	4878	4909	4939
1982	4970	5001	5029	5060	5090	5121	5151	5182	5213	5243	5274	5304
1983	5335	5366	5394	5425	5455	5486	5516	5547	5578	5608	5639	5669
1984	5700	5731	5760	5791	5821	5852	5882	5913	5944	5974	6005	6035
1985	6066	6097	6125	6156	6186	6217	6247	6278	6309	6339	6370	6400
1986	6431	6462	6490	6521	6551	6582	6612	6643	6674	6704	6735	6765
1987	6796	6827	6855	6886	6916	6947	6977	7008	7039	7069	7100	7130
1988	7161	7192	7221	7252	7282	7313	7343	7374	7405	7435	7466	7496
1989	7527	7558	7586	7617	7647	7678	7708	7739	7770	7800	7831	7861
1990	7892	7923	7951	7982	8012	8043	8073	8104	8135	8165	8196	8226

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

PERCENTAGE TABLE OF SCHEDULED AWARDS (IN WEEKS AND DAYS)
Federal Employees' Compensation Act

MEMBER		45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%
Arm	Wks.	140.40	156.00	171.60	187.20	202.80	218.40	234.00	249.60	265.20	280.80	296.40	312.00
	Days	982.80	1092.00	1201.20	1310.40	1419.60	1528.80	1638.00	1747.20	1856.40	1965.60	2074.80	2184.00
Leg	Wks.	129.60	144.00	158.40	172.80	187.20	201.60	216.00	230.40	244.80	259.20	273.60	288.00
	Days	907.20	1008.00	1108.80	1209.60	1310.40	1411.20	1512.00	1612.80	1713.60	1814.40	1915.20	2016.00
Hand	Wks.	109.80	122.00	134.20	146.40	158.60	170.80	183.00	195.20	207.40	219.60	231.80	244.00
	Days	768.60	854.00	939.40	1024.80	1110.20	1195.60	1281.00	1366.40	1451.80	1537.20	1622.60	1708.00
Foot/Penis	Wks.	92.25	102.50	112.75	123.00	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	Days	645.75	717.50	789.25	861.00	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Larynx/Tongue	Wks.	72.00	80.00	88.00	96.00	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
	Days	504.00	560.00	616.00	672.00	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Eye	Wks.	72.00	80.00	88.00	96.00	104.00	112.00	120.00	160.00	160.00	160.00	160.00	160.00
	Days	504.00	560.00	616.00	672.00	728.00	784.00	840.00	1120.00	1120.00	1120.00	1120.00	1120.00
Kidney/Lung	Wks.	70.20	78.00	85.80	93.60	101.40	109.20	117.00	124.80	132.60	140.40	148.20	156.00
	Days	491.40	546.00	600.60	655.20	709.80	764.40	819.00	873.60	928.20	982.80	1037.40	1092.00
Thumb	Wks.	33.75	37.50	41.25	45.00	48.75	52.50	56.25	60.00	63.75	67.50	71.25	75.00
	Days	236.25	262.50	288.75	315.00	341.25	367.50	393.75	420.00	446.25	472.50	498.75	525.00
1st Finger	Wks.	20.70	23.00	25.30	27.60	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00
	Days	144.90	161.00	177.10	193.20	209.30	225.40	241.50	257.60	273.70	289.80	305.90	322.00
Great Toe	Wks.	17.10	19.00	20.90	22.80	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00
	Days	119.70	133.00	146.30	159.60	172.90	186.20	199.50	212.80	226.10	239.40	252.70	266.00
2nd Finger	Wks.	13.50	15.00	16.50	18.00	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00
	Days	94.50	105.00	115.50	126.00	136.50	147.00	157.50	168.00	178.50	189.00	199.50	210.00
3rd Finger	Wks.	11.25	12.50	13.75	15.00	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00
	Days	78.75	87.50	96.25	105.00	113.75	122.50	131.25	140.00	148.75	157.50	166.25	175.00
Toe Other Than Great Toe	Wks.	7.20	8.00	8.80	9.60	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00
	Days	50.40	56.00	61.60	67.20	72.80	78.40	84.00	89.60	95.20	100.80	106.40	112.00
4th Finger	Wks.	6.75	7.50	8.25	9.00	9.75	10.50	11.25	12.00	12.75	13.50	14.25	15.00
	Days	47.25	52.50	57.75	63.00	68.25	73.50	78.75	84.00	89.25	94.50	99.75	105.00
Hearing (1 ear)	Wks.	23.40	26.00	28.60	31.20	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
Breast/Testicle	Days	163.80	182.00	200.20	218.40	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Hearing (2 ears)	Wks.	90.00	100.00	110.00	120.00	130.00	140.00	150.00	160.00	170.00	180.00	190.00	200.00
	Days	630.00	700.00	770.00	840.00	910.00	980.00	1050.00	1120.00	1190.00	1260.00	1330.00	1400.00

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

PERCENTAGE TABLE OF SCHEDULED AWARDS (IN WEEKS AND DAYS)
Federal Employees' Compensation Act

MEMBER		1%	2%	3%	4%	5%	10%	15%	20%	25%	30%	35%	40%
Arm	Wks.	3.12	6.24	9.36	12.48	15.60	31.20	46.80	62.40	78.00	93.60	109.20	124.80
	Days	21.84	43.68	65.52	87.36	109.20	218.40	327.60	436.80	546.00	655.20	764.40	873.60
Leg	Wks.	2.88	5.76	8.64	11.52	14.40	28.80	43.20	57.60	72.00	86.40	100.80	115.20
	Days	20.16	40.32	60.48	80.64	100.80	201.60	302.40	403.20	504.00	604.80	705.60	806.40
Hand	Wks.	2.44	4.88	7.32	9.76	12.20	24.40	36.60	48.80	61.00	73.20	85.40	97.60
	Days	17.08	34.16	51.24	68.32	85.40	170.80	256.20	341.60	427.00	512.40	597.80	683.20
Foot/Penis	Wks.	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00	51.25	61.50	71.75	82.00
	Days	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00	358.75	430.50	502.25	574.00
Larynx/Tongue	Wks.	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00	40.00	48.00	56.00	64.00
	Days	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00	280.00	336.00	392.00	448.00
Eye	Wks.	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00	40.00	48.00	56.00	64.00
	Days	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00	280.00	336.00	392.00	448.00
Kidney/Lung	Wks.	1.56	3.12	4.68	6.24	7.80	15.60	23.40	31.20	39.00	46.80	54.60	62.40
	Days	10.92	21.84	32.76	43.68	54.60	109.20	163.80	218.40	273.00	327.60	382.20	436.80
Thumb	Wks.	.75	1.50	2.25	3.00	3.75	7.50	11.25	15.00	18.75	22.50	26.25	30.00
	Days	5.25	10.50	15.75	21.00	26.25	52.50	78.75	105.00	131.25	157.50	183.75	210.00
1st Finger	Wks.	.46	.92	1.38	1.84	2.30	4.60	6.90	9.20	11.50	13.80	16.10	18.40
	Days	3.22	6.44	9.66	12.88	16.10	32.20	48.30	64.40	80.50	96.60	112.70	128.80
Great Toe	Wks.	.38	.76	1.14	1.52	1.90	3.80	5.70	7.60	9.50	11.40	13.30	15.20
	Days	2.66	5.32	7.98	10.64	13.30	26.60	39.90	53.20	66.50	79.80	93.10	106.40
2nd Finger	Wks.	.30	.60	.90	1.20	1.50	3.00	4.50	6.00	7.50	9.00	10.50	12.00
	Days	2.10	4.20	6.30	8.40	10.50	21.00	31.50	42.00	52.50	63.00	73.50	84.00
3rd Finger	Wks.	.25	.50	.75	1.00	1.25	2.50	3.75	5.00	6.25	7.50	8.75	10.00
	Days	1.75	3.50	5.25	7.00	8.75	17.50	26.25	35.00	43.75	52.50	61.25	70.00
Toe Other Than Great Toe	Wks.	.16	.32	.48	.64	.80	1.60	2.40	3.20	4.00	4.80	5.60	6.40
	Days	1.12	2.24	3.36	4.48	5.60	11.20	16.80	22.40	28.00	33.60	39.20	44.80
4th Finger	Wks.	.15	.30	.45	.60	.75	1.50	2.25	3.00	3.75	4.50	5.25	6.00
	Days	1.05	2.10	3.15	4.20	5.25	10.50	15.75	21.00	26.25	31.50	36.75	42.00
Hearing (1 ear) Breast/Testicle	Wks.	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80
	Days	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80	91.00	109.20	127.40	145.60
Hearing (2 ears)	Wks.	2.00	4.00	6.00	8.00	10.00	20.00	30.00	40.00	50.00	60.00	70.00	80.00
	Days	14.00	28.00	42.00	56.00	70.00	140.00	210.00	280.00	350.00	420.00	490.00	560.00

(see next page for 45 - 100 percent)

Form CA-699
Rev. June 1980

Writing Effective Letters

General Guidelines

- Keep the letter brief (one page, 3-5 paragraphs)
- Stick to objective facts -- don't get personally involved
- Avoid any mention of discrimination that may be alleged by claimant or other interested party
- Avoid placing blame
- Use clear, short, concise sentences
- Be aware of your "audience" - direct your letter to the apparent educational level, language and background of your reader:
  - Attorneys or congressional staff may be quite familiar with the law
  - Many claimants may not understand the language of Workers' Comp. - use simple terms, no abbreviations or jargon; use short sentences.
  - If appropriate, write (or locate someone in the office who can write) in the claimant's native language
- Focus on specifics -- refer to your knowledge of the case
- Use correct grammar, punctuation and spelling
- Accentuate the positive (e.g, what is compensable rather than what is not compensable)
- Provide only relevant information
- Check your letters for clarity and ease of comprehension
- Proofread the letter when it is returned from the typist

To Write an Effective Letter (All Letters)

- In the opening paragraph - state the purpose of the letter:
  - Refer to any previous letter or contact, by date
  - State the specific incident that necessitates the letter
- In the body of the letter - respond to the specific question or request for information:
  - Make reference to the fact that you have, as appropriate, referred to the claimant's file (e.g., "Our records show that ....")

- When responding to a claim for compensation, mention the compensable disability and whether it, in fact, occurred while in the performance of duty and was due to factors of employment; include the date of injury, the claimant's occupation and employing Agency.

- As appropriate, state the type of compensation payable, amount and dates payable.

- Provide only the necessary facts or relevant information.

- If a claim is being rejected, always give a reason.

- Be specific!

o In the closing paragraph:

- State any future action that might be taken, either by OWCP or by the claimant.

- Apologize for any delay in answering

- As appropriate, express some regret that the reply is not in the claimant's favor

Congressional Letters (in response to inquiries on behalf of their constituents)

o Opening - state the purpose of the letter

o Body

- State what the claimant is filing for (brief history)
- State what compensation has been paid
- Answer specific questions

o Closing - verify what action has been taken

Phone Contact with Claimants

o Contact with claimant - "rules of thumb":

- Be polite
- Be sympathetic (claimant "hurts")
- Let person talk (CE listens!)
- Don't antagonize
- Speak slowly and distinctly
- No need to take personal abuse
- Pass along call if you don't understand claimant (e.g., language or accent)
- Don't make promises you can't keep
- Pass abusive or problematic alls to Supervisor

o Calls may average 40 per day.

o Typical kinds of calls	Frequency (In descending order)
- When am I getting my next check?! or how come my check is late? - Has my bill been paid? - Has my travel voucher been processed?	80-90% of calls - (1)
- What is status of my case? or when will it be approved?	(2)
- Why was my compensation cut?	(3)
- General information requests: . How do I file a claim? . What is the law?	(4)
- Explain this letter or comp. order. - Can I get medical treatment? - Can I re-open my case? - Can I change doctors? - Can I get a scheduled award? - Why do I need a medical evaluation?	(5)

THIRD-PARTY LIABILITY ("3P")

Reference: FECA BULLETIN NO. 80-20. FECA Release 80-40
FECA, #8131, #8132.

GENERAL PRINCIPLES

- Definition - Injury caused by person or object under circumstances which indicate there is a legal liability on a party other than the U.S. Government to pay the damages.

  - Almost always an issue in injury claims; occasionally occurs in disease claims.

  - The designated CE can handle 3P cases under $1,000.00 including settlement as long as an attorney is not involved, and/or the case is not of a complex or serious nature.

  - The claims examiner automatically sends the 3rd Party aspect of the case to the designated claims examiner (DCE) when:

    - the injury is not minor and an attorney is involved in the case

    - a case is not minor (over $1,000.00) and the claimant refuses to pursue the third party claim or does not reply to Form Letter CA-1045 or equivalent, OR

    - the third party case falls within one or more of the following classifications listed below:

      a. Death claims
      b. Permanent disability
      c. Job Corps and YACC
      d. Peace Corps
      e. VISTA
      f. Cases where the injuries occurred outside the United States or Canada
      g. Cases where the potential defendant is a common carrier
      h. Cases involving malpractice
      i. Cases involving product liability
      j. Cases involving injuries to more than one employee

NOTE: Government agencies do not constitute a THIRD-Party Liability. However, a government employee who has caused injury to another government employee even though it occurred in the performance of duty may be subject to 3rd P. Liability.

To ensure each claimant is knowledgeable of his/her responsibility under the Act regarding THIRD-Party Liability, a CA-801, Post card to Claimant and Employer, is sent by the DAY-TEL Unit or CE (depending on office policy) at the time the case is invented.

o Indicators of Third-Party Liability:

- Cause of injury (CA-1, #13) - indicates how the injury occurred and whether a third-party may be involved (e.g., chair collapsed; dog bite; auto accident, etc.)

- Nature of injury (CA-1, #14) - indicates seriousness of injury.

    o "Minor" injury - an injury where the employee's total medical bills, compensation, and/or time lost from work (including sick or annual leave or continuation of pay used to cover the absence) do not exceed or are not expected to exceed $1,000.00.

    o "Major" injury - medical bills and disbursements (includes salary, COP, compensation, and sick or annual leave) over $1,000.00 or is anticipated due to the type of injury (i.e., herniated disc, torn medial meniscus, etc.).

- Witness Statement (CA-1, #17) - may verify cause of injury.

- 3P Question (CA-1, #17) - indicates whether a third-party is involved. This item must be completed.

- Accident Report (if one is submitted) - may provide additional information concerning cause of injury.

o ACTIONS TO TAKE when 3P is involved:

- At time of primary development, CE upon identifying possible 3P, sends CA-1045 to claimant or survivor, with a copy to OS. Place copy in case file and give case to DCE for logging. Place a 30-day call-up on case. When the CA-1045 is returned, refer case to DCE for action.

- On Summary Sheet (CA-800) note in block #53 that CA-1045 has been sent, initial and date.

- Initiate at once request for all information needed to determine 3rd P potential as appropriate.

    - o Accident and investigative reports
    - o Names, addresses, and statements of witnesses
    - o Diagrams and/or photographs
    - o Any other information deemed useful.

- When a CA-3 comes in (e.g., when COP expires) look at Part B (Continuation of Pay) in order to identify dates and amount of COP paid. This amount is included in disbursements, the amount of which affects the DCE's decision to send the case to RSOL. Also, if amount of COP causes disbursement to exceed $1,000, refer case to DCE.

- Also, look at item #59 (Medical and Related Expenses) on the CA-800. The total disbursements (from item #59 on CA-800 and items #13, 18 of CA-3) influence whether you have a 3rd P case below or above $1,000.00. If over $1,000 refer case immediately to DCE.

- Monitor disbursements in all potential 3rd P cases every 30 days to insure the cost of the case is such as to continue to be considered minor.

o Method of Refund

- In instances where the claimant is unable to make refund out of the 3rd P recovery, the DCE should consult the SOL for advice.

- 3rd P Disbursement Chargeback Credit & COP Refund to Agency

    - o Completion and submission of Form CA-135 (Chargeback Code Schedule) is done by the Fiscal Section of the district office. A completed Form CA-162 is attached to the original of the CA-135 and sent to the Division of Budget and Finance, Branch of Program Operations and Fund Control, ESA, Rm. C-3205, NDOL, Washington, D. C. 20210, for further submission to Data Processing.

    - o Refund includes COP

        - Since COP is not compensation, it is not to be returned to the employing agency through the chargeback system. DCE prepares a memorandum to the fiscal officer with a

copy for the file. Advises fiscal officer that:

1) 3rd P check includes COP,
2) COP is not to be credited to the employing agency through the chargeback system, and
3) a check for the amount of COP be issued directly to the employing agency.

o Depositing 3rd P Funds Received by NO SOL

- NSOL sends check to the NO's Branch of Special Claims (District #50) for deposit, with a copy of the refund check and the original CA-162 to the appropriate district office.

- DCE reviews the CA-162 for accuracy. Places a copy of refund check and CA-162 in file, and forwards a copy of same to fiscal for completion of CA-135. Make appropriate entry in the Cash Receipt Register noting "Check Deposited in National Office".

o Monthly Report

- DCE maintains a record of 3rd P cases identified, settled, and amounts recovered to be included on a monthly basis. Form CA-80 is used as the monthly report form.

o ACTIONS TO TAKE when CA-1045 is not returned:

- If CA-1045 is not received within 30 days:

1. Release a 2nd CA-1045 marked " SECOND REQUEST".
2. Place a 2nd 30-day call-up on case;
3. Refer case to DCE if no response is received.
4. DCE can close case if disbursement is under $1,000 and the case does not fall within one of the following categories:

   a. Death claims
   b. Permanent disability
   c. Job Corps and YACC
   d. Peace Corps
   e. VISTA
   f. Cases where the injuries occurred outside of United States or Canada
   g. Cases where the potential defendant is a common carrier
   h. Cases involving malpractice
   i. Cases involving product liability
   j. Cases involving injuries to more than one employee, or

- Where it is determined from the circumstances of the case that further efforts to effect a recovery would not be successful, such as the:

  o applicable statute of limitations has run out,
  o negligent third-party cannot be identified,
  o negligent third-party has left the jurisdiction and recovery cannot be pursued, or
  o negligent third-party has no assets from which recovery can be made.

  Any questions concerning the above, should be referred to RSOL.

- Prior to closure, designated CE should consult the RSOL or SOL as appropriate.

  If the case exceeds $1,000 or falls within one of the above categories, the DCE should write to the employing agency for assistance and refer the case to the appropriate RSOL or SOL.

o ACTIONS TO TAKE when case is referred to RSOL or SOL:

- Make initial referral by completing Form CA-160

  Photograph copies of CA-forms (listed on CA-160) and other pertinent documents:

  1. witness statements
  2. accident reports
  3. diagrams and photographs
  4. medical reports
  5. correspondence from attorney
  6. investigative reports

- Advise claimant by letter 3P aspect of case is handled by the appropriate RSOL.

- Enter the notation "Referred to SOL" in item #53 of Form CA-800 (summary) or the "Remarks" section of Form CA-105, initial and date.

o ACTIONS TO TAKE after case is referred to RSOL or SOL:

- Send RSOL or SOL recent disbursements upon request, or, at a minimum, six-month intervals. Include all other pertinent information at that time.

- Documents considered urgent by the DCE should be sent to the RSOL or SOL immediately using Form CA-160.

- Advise RSOL or SOL when claimant is placed on AR, use CA-160. Furnish copy of letters CA-1048, CA-1049, Form CA-180, or CA-181. Place copy of each document sent in case in file.

- Notify RSOL or SOL when condition of claimant changes, e.g., worsens, returns to work, permanent impairment, etc.

- If RSOL or SOL advises that settlement is made or near:

  1) Prepare a CA-161 (statement of disbursement) and send to office handling the case,
  2) Note whether or not claimant is on the PR,
  3) When CA-162 is received from RSOL or SOL,
     a) review for errors such as incorrect amounts and mathematical errors; b) terminate or suspend claimant from PR if a 3rd P credit exists. This will be reflected on the CA-162.

4) Apply any impending compensation payments and/or medical bill payments to the 3rd P credit.
5) Make a one-line entry on Form CA-800, or CA-105 to show the amount of 3rd P credit, certify only if the amount credited is a correction to the amount on the CA-162.
6) If a refund check is received with the statement of recovery (CA-162) place a copy of the check in the file and forward the check to fiscal with a copy of the CA-162 for further disposition.
7) Release letter CA-1044 if there is a 3rd P Credit, otherwise send a CA-1120 if no credit. Release of either letter should be noted on the non-Fatal Summary.

Type of Case	Indicators	CE Actions to Take
Under $1,000	o No Tort liability apparent o Absence less than 3 days from work o Medical expense less than $500 o Disbursements less than $500 o Less than 10 out-patient visits o Claimant says won't bring suit o Claimant unable to, or has not, retained an attorney.	o If after considering the indicators, the liability is under $1,000 and the claimant has not obtained an attorney, refer to DCE for closure. -Complete Form CA-1123; -Make summary entry in #53 of CA-800 or "remarks" Section of CA-105, date and initial. -Note the word "closed" in #53.
Over $1,000.00	o A Tort liability exists o Disbursements will exceed $1,000.00 NOTE: "Disbursements" include: salary, COP, compensation, sick and annual leave, and medical bills o If disbursements are over $1,000.00 claimant must be encouraged to pursue 3rd P. Liability.	o Send CA-1045 to claimant or survivors with copy to OS and case file -Send to attorney CA-1108; CA-1109 (2 copies, signed by CE); CA-161 with injury forms shown on CA-160, and 2 blank CA-162's; carbon of CA-1045; copies of case records: CA-1, medical report, accident report. DO NOT include any internal memos or documents). o On Summary Sheet, note (#53) that CA-1045 and CA-1108 were sent, initial and date.

Type of Case	Indicators	CE Actions to Take
Special	o Death cases o Permanent disability o Job Corps, Peace Corps, VISTA, YACC o Claimant injured on common carrier o Injury outside U.S., Canada, or territories o Malpractice o Cases involving product liability (difficult to prove) o Cases involving more than 1 employee o Cases involving exposure to asbestosis or anu other hazardous substances.	o Forward pertinent materials regarding case to *DCE.

*Cases arising in Districts 25 and 50 are referred to the Employee Benefits Division, Office of the Solicitor, Washington, D.C. 20210

See next page for description of 3P forms.

THIRD-PARTY FORMS

	Purpose or Use
CA-135	Charge-back Code Schedule - Used as a schedule to credit the employing agency with the amount received for OWCP disbursements, and the amount received for COP.
CA-160	Used to refer 3rd P. material to the SOL.
CA-161	Indicates disbursements made by OWCP; sent to attorney
CA-162	Statement of Recovery Form; sent to attorney
CA-166	Fiscal use; apportions refund between EA and OWCP
CA-168	Third Party Recovery - Monthly report to SOL
CA-170	Release by RSOL to attorney or insurance company that authorizes settlement and discharges the liability of the third-party
CA-1044	Form sent to claimant after settlement; indicates whether 3P credit still exists.
CA-1045	Advises claimant of: the right to present a claim; how to credit 3P net recovery to possible future compensation; the right to engage an attorney. It is usually sent when a CA-1038 is released.
CA-1108	Letter to attorney authorizing release of information & CA-162
CA-1109	Authorization form sent to medical establishment or to EA to release information to attorney or insurance company; but more "legalistic"' CC to attorney
CA-1110	Letter to EA or attorney requesting current status of the 3P case/settlement
CA-1111	Letter to insurance company apprising of OWCP lien-- requests current status of settlement
CA-801	Now being sent at time of case creation. Replaces CA-1116.
CA-1120	Used to close case when no recovery was obtained
CA-1121	Request for information concerning 3rd P. aspect
CA-1122	Employee statement of Recovery - used in cases where no attorney is involved - minor cases.

STATE STATUTES OF LIMITATIONS
FOR PERSONAL INJURIES
(WRONGFUL DEATH, MEDICAL MALPRACTICE,
AND/OR PRODUCTS LIABILITY MAY BE DIFFERENT)

State	Personal Injury	State	Personal Injury
ALABAMA	1 Year	MONTANA	3 Years
ALASKA	2 Years	NEBRASKA	4 Years
ARIZONA	2 Years	NEVADA	2 Years
ARKANSAS	3 Years	NEW HAMPSHIRE	6 Years
CALIFORNIA	1 Year	NEW JERSEY	2 Years
COLORADO	6 Years	NEW MEXICO	3 Years
CONNECTICUT	2 years from discovery but not more than 3 years	NEW YORK	3 Years
DELAWARE	2 Years	NORTH CAROLINA	3 Years
DISTRICT OF COLUMBIA	3 Years	NORTH DAKOTA	6 Years
FLORIDA	4 Years	OHIO	2 Years
GEORGIA	2 Years	OKLAHOMA	2 Years
HAWAII	2 Years	OREGON	2 Years
IDAHO	2 Years	PENNSYLVANIA	2 Years
ILLINOIS	2 Years	PUERTO RICO	1 Year
INDIANA	2 Years	RHODE ISLAND	3 Years
IOWA	2 Years	SOUTH CAROLINA	6 Years
KANSAS	2 years from reasonable ascertainability but not more than 10 years	SOUTH DAKOTA	3 Years
KENTUCKY	1 Year	TENNESSEE	1 Year
LOUISIANA	1 Year	TEXAS	2 Years
MAINE	6 Years	UTAH	4 Years
MARYLAND	3 Years	VERMONT	3 Years
MASSACHUSETTS	2 years; 3 years for hit and run	VIRGINIA	2 Years
MICHIGAN	3 Years	WASHINGTON	2 Years
MINNESOTA	6 Years	WEST VIRGINIA	2 Years
MISSISSIPPI	6 Years	WISCONSIN	3 Years
MISSOURI	5 Years	WYOMING	4 Years

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